STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF MANAGEMENT AND BUDGET

P.O. BOX 30026, LANSING, MICHIGAN 48909
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Office of Health and Medical Affairs
Telephone 517/373-8155/373-9650

MEMORANDUM

DATE: December 30, 1985

TO: Statewide Health Coordinating Council and Interested Parties

FROM: OHMA Staff

SUBJECT: Educational Session on Medical Malpractice Issues

For the educational session on January 16, 1986, the OHMA staff have invited the Michigan State Medical Society(MSMS) and the Michigan Citizens Against Incompetent Medicine(MAIM) to each send a representative. Carl Gagliardi, M.D., Chairman of the Board of Directors for the MSMS has agreed to come and we expect to receive the name of a representative from MAIM shortly. Each has been asked to give the SHCC comments and reactions related to the Final Report to Governor James J. Blanchard on the subject of Health Care Provider Malpractice and Malpractice Insurance from the Governor's appointed factfinder, Robben W. Fleming. A copy of that report is provided to you for your review. Mr. Fleming was also invited to address the SHCC. However, he is on his way to an extended stay in Florida and will not be available.

In addition to Mr. Fleming's report, the following are included as background materials for this session:

December 6, 1985 letter to S. Miner from Steven Scheer, Deputy Director, Michigan Hospital Association

Handout from MAIM - The Myth of a "Malpractice Crisis"

Public Citizen Health Research Group Report: Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform

MAIM - Recommendations for Improving Health Care Delivery

Memorandum from MAIM on their opposition to SB 470

Ralph Nader Press Conference, November 19, 1985 relating to the malpractice crisis

Department of Licensing and Regulation, Needed changes in Departmental practices, purpose and regulatory framework

Excerpts from "A Report on Civil Justice in Michigan" by the Senate Select Committee on Civil Justice Reform, September 26, 1985

Medical Malpractice Report from Nancy Baerwaldt, Commissioner of Insurance, July 19, 1985

SHCC Education Report

Medical Malpractice Insurance

January 16, 1986

Summary
Final Report to Gov. James J. Blanchard on the subject of Health Care Provider Malpractice and Malpractice Insurance

Robben W. Fleming
December 17, 1985

Introduction

This report sets forth findings and recommendations pertaining to health care provider malpractice and malpractice insurance in Michigan. It includes a series of determinations as to the nature of the present "crisis" and a series of proposals for responding to the present situation.

Findings

The report's findings include the following:

1) The existing situation is sufficiently serious as to warrant remedial action at this time.

2) The current situation is, generally, not the result of abuses of the present system by providers, insurers, attorneys, or patients.

3) It is important to distinguish between malpractice and maloccurrences (i.e., adverse clinical results) which are not the result of negligence. This distinction is in danger of being lost in the current debate.

4) A significantly greater amount of malpractice evidently occurs than is implied by the number of claims filed.

5) With respect to malpractice claims, a preliminary analysis suggests that a disproportionately large number are attributable to a comparatively small number of physicians, and that this pattern appears to hold within each specialty.

6) Little systematic effort goes into the prevention of malpractice.

7) The frequency with which claims are filed has increased significantly over the past decade.

8) Indemnities which are paid to plaintiffs, as well as the expenses associated with the investigation and defense of claims, have grown significantly over the past decade.

9) Malpractice insurance premiums have risen sharply in the past two years, but, in inflation-adjusted terms, the costs of insurance are generally equivalent to those of 1976.

10) Malpractice insurance remains generally available.

Recommendations

The report's recommendations include the following:

1) The actions of the Governor and legislature should proceed in two phases: an immediate set of actions and a set that would take place in early 1986.

2) The immediate actions should include the following set of tort reforms: revision of the doctrine of joint and several liability; revision of the collateral source rule; mandating the use of structured payments for awards; adjustment of the pre-judgment interest requirement; establishment of statutory provisions for the assignment of costs in "frivolous" cases; and refinment of the statute of limitations.

3) The following tort reforms should not be enacted: qualification of expert witnesses; mandating the use of pre-trial screening panels; and the establishment of a limit of non-economic damages.

4) A state-administered fund should be created to serve as the source of payment for so-called "long-tail" claims, i.e., claims which are filed long after the incident in connection with which negligence is alleged, and to serve as the source of payment for that portion of awards and settlements against physicians which exceeds a certain threshhold. The fund would be financed by assessments on all of the state's physicians.

5) The recommended tort reforms and the creation of the fund should be made contingent upon the implementation of enhanced systems for assuring the competency of physicians and preventing malpractice. These systems would be devised in early 1986 and would involve greatly intensified efforts on the parts of the profession, the insurers, and the state. Such systems are envisioned to include a much expanded program of self-regulation by the profession under the supervision of the state.

6) Malpractice insurance premiums should be frozen through June 30, 1986.

7) The actions proposed for 1986 should include inquiries into the development of alternative ways of classifying physicians for purposes of establishing risk; into the development of alternative dispute resolution techniques; into the past practices of the state's insurers and the Insurance Bureau; and into the benefits of so-called "no-fault" options.

8) The Governor should designate an individual or entity to manage and coordinate the actions proposed for 1986.

FINAL REPORT

to

GOVERNOR JAMES J. BLANCHARD

on the subject of

HEALTH CARE PROVIDER MALPRACTICE AND MALPRACTICE INSURANCE

Robben W. Fleming

December 17, 1985

December 17, 1985

Governor James J. Blanchard
Capitol Building
Lansing, Michigan

Dear Governor Blanchard:

At the time of my appointment on September 25, 1985, you asked me to find and report the facts in connection with health care provider malpractice and malpractice insurance in Michigan. You also made available the services of Jay Rosen and state agency personnel, all of whom have been invaluable. In addition, I have had the cooperation of all interested parties, including the malpractice insurers, the Michigan State Medical Society, the State Bar of Michigan, groups representing consumer interests, and a host of others.

Given the time-frame within which this report has had to be prepared, it has not been possible to undertake original or exhaustive research. There are still many unanswered questions. Nevertheless, within the limitations of time and information, I am pleased to give you my judgment on the matters in question.

More specifically, in the course of this report I have attempted to:

- Identify the important facts in the present health care malpractice dilemma;
- State my conclusions as to the seriousness of the situation and its root causes;
- Assess the adequacy of the tort reforms which are under discussion in the legislature; and
- Offer my own recommendations for resolution of the problem.

In the event you find merit in these conclusions, I have also suggested a means by which the recommendations can be implemented. This would require a two-phase plan, part of which would result in immediate action and part of which would be delayed into 1986. Since the two are intimately inter-related it would be necessary to package them in a fashion which would tie them together.

For the first phase, I have suggested a way in which malpractice insurance premium rates could be momentarily stabilized, and have proposed a list of tort reform and other measures which could be passed.

In the second phase, occurring in 1986, four lines of inquiry into more fundamental changes would be made and would result in recommendations and action. The inquiries would involve:

- The development of a major government-private sector plan to reduce the amount of malpractice which now occurs.
- The further consideration of alternative dispute resolution methods now being used elsewhere in an effort to deal with claims more expeditiously, fairly, and in a less costly manner.

- The careful examination of medical liability insurance company practices; and
- An assessment of the viability of a no-fault insurance system which might apply in some carefully defined way to health care liability problems.

I have further proposed mechanisms by which these areas should be investigated and acted upon, and, in particular, have proposed that these activities be coordinated through either an individual or entity designated by you. Time limitations on each of the studies would be established, with reports and recommendations available in time for action in mid-1986.

I hope this report will be of some value to you. I shall be glad to discuss it with you and with others at your convenience.

Sincerely,

Robben W. Fleming

FINAL REPORT

to

GOVERNOR JAMES J. BLANCHARD

on the subject of

HEALTH CARE PROVIDER MALPRACTICE AND MALPRACTICE INSURANCE

Robben W. Fleming

December 17, 1985

I. SUMMARY OF FINDINGS AND RECOMMENDATIONS

FINDINGS

General Findings

Finding 1: There can be little doubt that the systems which we have devised for identifying instances of malpractice, adjudicating malpractice claims, and compensating victims of malpractice are not operating in an optimal fashion. It is my judgment that the deficiencies in these systems warrant modifications.

Finding 2: The current climate with respect to medical liability has had a substantial impact on the ways in which health care services are provided to patients. While many of these effects are clearly undesirable, some are not. It is important to keep in mind that the concept of medical liability, by creating a deterrent to unacceptable health care practices, makes a contribution to the maintenance of high standards of quality for health care.

Finding 3: It should not be assumed that the stresses which are being exhibited by the medical liability system necessarily reflect abuses of that system. It is important to recognize that even the legitimate use of social institutions, such as the medical liability system, causes them to change over time, thereby making reform necessary.

Findings as to the Nature and Incidence of Malpractice

Finding 4: It is universally agreed that genuine cases of malpractice occur, and that when they do the victim ought to be compensated. Thus, there is no challenge to the proposition that negligence in the course of the provision of health care services generates a legitimate greivance on the part of the patient and a genuine liability on the part of the health care professional or institution.

Finding 5: Physicians, hospital staff, and other health personnel practice an imperfect and ever-changing art. There will be failures which are not attributable to negligence and which, if compensated, should not be compensated on a negligence theory.

Finding 6: While it is difficult to quantify the incidence of malpractice, many studies have concluded that there are more instances of malpractice than there are claims submitted.

Finding 7: It is universally agreed that there are known incompetent health care professionals practicing in Michigan and that steps can and should be taken to eliminate the threat which such individuals pose to the public.

Finding 8: While it is widely agreed that incompetent professionals are practicing in Michigan today and that such individuals are in part responsible for the injuries that occur to patients, a disproportionate share of malpractice incidents are attributable to a significant minority of professionals who are basically competent and who, in general, provide care of acceptable quality to patients. The best opportunity to reduce the incidence of malpractice, and thus, to reduce the number and cost of malpractice claims, lies in devising methods of helping these providers minimize the number of accidents which occur to their patients.

Finding 9: In general, insurers in this state have engaged in little or no risk management, loss prevention, or quality assurance activities, despite the existence of strong evidence that the potential for malpractice can be reduced by the use of such techniques.

Findings as to the Nature, Number, Disposition and Costs of Malpractice Claims

Finding 10: A review of Michigan's malpractice claims experience over the past ten years suggests that the single most important development has been the very substantial increase in the number of malpractice claims.

Finding 11: Such a review further indicates that, over the past ten years, average indemnity payments have increased substantially, but that the trends vary from insurer to insurer and are characterized by large year-to-year changes in both directions.

Finding 12: Over the past ten years, the average cost of defending against a malpractice claim has increased substantially, but the trends vary from insurer to insurer.

Finding 13: The pattern of claims disposition has not changed significantly over the past ten years; though this varies from insurer to insurer, over this period, approximately 40%-50% of all claims were closed with an indemnity payment, while 50%-60% were closed with no indemnity payment.

Finding 14: Processing malpractice claims through the courts on a tort theory is a very expensive and time-consuming way to adjudicate such claims.

Findings as to the Cost and Availability of Malpractice Insurance

Finding 15: For physicians, between 1976 and 1985, malpractice insurance premiums charged by the majority of insurers did not generally increase by significant amounts in real (i.e., inflation-adjusted) terms. In fact, the inflation-adjusted costs of malpractice premiums for many physicians decreased, in some cases substantially.

Finding 16: For the majority of insurers, the trend in physician premiums shows that between 1976 and 1982, premiums declined by about half in real terms. Between 1982 and 1985, premiums increased dramatically, so that, in real terms, 1985 levels are generally at 1976 levels.

Finding 17: The experience of hospitals has mirrored that of physicians. That is, premiums declined sharply between 1976 and 1981, and increased between 1982 and 1984, and increased significantly between 1984 and 1985. As with physician premiums, an analysis of premiums in real (i.e., inflation-adjusted) terms shows that 1985 premiums are roughly equal to 1976 premiums.

Finding 18: Malpractice insurance premiums have exhibited an extreme volatility, despite what appears in retrospect to have been a fairly clear and consistent set of trends in the underlying determinants of the premiums.

Finding 19: Large-scale economic variables, such as interest rates and liability insurance industry cycles appear to have played a substantial but limited role in the setting of premiums over the past decade.

Finding 20: In general, malpractice insurance remains available. Policies with certain very high limits appear to be increasingly difficult to obtain, but there is little evidence of widespread availability problems.

RECOMMENDATIONS

General recommendations

Recommendation 1: The development and implementation of measures to resolve the malpractice problem should be divided into two phases. Phase I consists of a series of actions which can and should be taken immediately. These actions are set forth in Recommendations 3 through 7. Phase II consists of a series of steps which cannot be undertaken without extensive preparation in early 1986. These actions are set forth in Recommendations 8 through 13.

Recommendation 2: Given the interrelationships between the elements of Phase I and those of Phase II, it is essential that the implementation of these recommendations be overseen and coordinated by a single individual or entity, designated by the Governor for this purpose.

Recommendations for Phase I: Immediate Actions

Recommendation 3: The legislature should enact a package of tort reforms including the following elements: revision of the doctrine of joint and several liability; adjustment of the collateral source rule; mandating the use of structured awards; adjustment of the statute pertaining to pre-judgment interest; the creation of statutory authority for the assignment of costs in frivolous actions; and refinements to the statute of limitations.

Though these reforms should be made effective immediately, they should expire by June 30, 1986 unless the governor certifies to the legislature prior to that date that, by various legislative, administrative and private means, the following have been achieved: the enactment of an expanded state system for assuring the competency of providers, and the design and implementation of effective insurer-sponsored programs of risk management and loss prevention. See Recommendations 8 and 9.

Recommendation 4: The legislature should decline to enact the following tort reform proposals: the qualification of expert witnesses; the mandatory use of pre-trial screening panels; and a limit on non-economic damages.

Recommendation 5: The legislature should create a state-administered Medical Liability Fund. The Fund would be the source of payment for selected awards. Possible cases for payment out of this Fund would be all those in which a claim is asserted more than a certain number of years after its occurrence, provided the claim is valid under the statute of limitations, and that portion of all awards against physicians in excess of some dollar threshhold. The Fund would be financed by a flat annual assessment on all licensed physicians.

Use of the Fund should commence on July 1, 1986, provided that the Governor certifies to the legislature by that date that, by various legislative, administative, and private means, the following have been achieved: the enactment of an expanded state system for assuring the competency of providers, and the design and implementation of effective insurer-sponsored programs of risk management and loss prevention. See Recommendations 8 and 9.

Recommendation 6: Malpractice insurance premiums should be frozen at their December 1, 1985 levels until June 30, 1986. Such a freeze should be undertaken voluntarily by malpractice insurers, but, if necessary, should be achieved by appropriate legislative or administrative means.

Recommendation 7: The legislature should enact a set of measures roughly along the lines of those which have been incorporated into the proposals of both houses pertaining to the strengthening of the state's disciplinary system.

Recommendations for Phase II: Actions in 1986

Recommendation 8: Beginning immediately, and continuing through the first half of 1986, the Governor's Designated Representative should supervise the development of a major expansion of the system by which the competency of providers is evaluated and maintained. Such an effort should involve, at a minimum, the state officials responsible for the licensing and regulation of providers and the professional organizations which represent the state's providers.

This effort should be aimed at the enactment of such an expanded system by June 30, 1986, so that the Governor can make the appropriate certifications to the legislature as described in Recommendations 3 and 5.

Recommendation 9: Beginning immediately, and continuing through the first half of 1986, the Governor's Designated Representative should supervise the development of insurer-sponsored risk management and loss prevention programs. Such an effort should involve, at minimum, the state's malpractice insurers, the professional organizations which represent the state's providers, and the state's insurance officials.

This effort should be aimed at the implementation of such programs by July 1, 1986, so that the Governor can make the appropriate certifications to the legislature as described in Recommendations 3 and 5.

Recommendation 10: Beginning immediately, and continuing through the first half of 1986, the Governor's Designated Representative should supervise the development of alternative systems of rate classifications for physicians for the purpose of narrowing the wide differences in premiums paid by the lowest and highest risk classes. This effort should involve the state's malpractice insurers, professional organizations representing the state's providers, and the state's insurance officials.

Beginning July 1, 1986, the Insurance Commissioner should, with respect to liability insurance for physicians, require the use of an alternative system of rate classifications.

Recommendation 11: The Governor's Designated Representative should arrange for and supervise an investigation of the practices of malpractice insurers for the purpose of ascertaining whether the performance of these insurers has, in the past, been satisfactory with respect to the manner in which premiums have been set, the manner in which reserves have been established, and other related issues. In addition, an assessment should be made as to whether the current level of state regulation and supervision is sufficient for the future. This investigation should be completed no later than June 30, 1986.

Recommendation 12: The Governor's Designated Representative should supervise an examination of the various alternative methods of dispute resolution which might make the medical liability system less costly and more efficient. The results of this inquiry should be supplied to the legislature not later than July 1, 1986.

Recommendation 13: The Governor's Designated Representative should arrange for and supervise a study of the potential benefits of a "no-fault" system of malpractice insurance. Such a study should be completed by January 1, 1987.

II. FINDINGS

Introduction

The problem with simply finding the facts in a situation of this kind is that while the facts give one a picture of the problem and its complexities, they do not suggest a clear and effective solution. Nevertheless, finding the facts may be the beginning of wisdom as one looks for solutions. Accordingly, I present the following findings.

General Findings

Finding 1: There can be little doubt that the systems which we have devised for identifying instances of malpractice, adjudicating malpractice claims, and compensating victims of malpractice are not operating in an optimal fashion. It is my judgment that the deficiencies in these systems warrant modifications.

Finding 2: The current climate with respect to medical liability has had a substantial impact on the ways in which health care services are provided to patients. While many of these effects are clearly undesirable, some are not. It is important to keep in mind that the concept of medical liability, by creating a deterrent to unacceptable health care practices, makes a contribution to the maintenance of high standards of quality for health care.

Finding 3: It should not be assumed that the stresses which are being exhibited by the medical liability system necessarily reflect abuses of that system. It is important to recognize that even the legitimate use of social institutions, such as the medical liability system, causes them to change over time, thereby making reform necessary.

Discussion

There is little question that some type of reform of the medical liability system is needed at this time. The symptoms of the present "crisis" reflect genuine deficiencies in the capacity of the current system to effectively and efficiently identify, evaluate, and compensate medical malpractice. By way of introduction, I wish to make the following observations.

First, and most importantly, we cannot hope to maintain the generally high standards of care to which we are accustomed if the relationship between providers and patients becomes adversarial. It is in the public interest that patients have a high level of confidence in the people and institutions who comprise the health care system, and, correspondingly, it is desirable that providers not come to view each patient as a potential litigant. Therefore, to the degree that the current situation surrounding medical malpractice

threatens the ability of providers and patients to reasonably interact in an environment of trust and confidence, it will be necessary to take action to mitigate this danger.

On the other hand, care should be taken not to overstate the magnitude of the problem and the effects which it is having on our health care system. Of the millions of encounters which physicians and patients have each year, and of the hundreds of thousands of hospital admissions, only a very small fraction result in malpractice claims. Therefore, it would be a mistake to conclude that the basic underlying relationships between providers and patients have suffered irreparable injury.

Second, any analysis of the medical liability system should begin with a clear notion of what that system is expected to achieve. It is important to keep in mind that medical liability is generally considered to have two principal aims: to compensate victims and to deter substandard medical practices.[1]

Third, the medical liability "crisis" has been an acrimonious one, and many of the parties at interest have sought to place the blame for the present problem on the behavior of other parties. In general, I believe that this is an understandable but inaccurate way of looking at the issue. There is little evidence to support the conclusion that the present situation is the result of systematic abuses by any of gthe parties. Physicians and hospitals are not routinely injuring patients, attorneys are not indiscriminatinely encouraging patients to bring actions which are without cause, and patients are not automatically initiating actions whenever they suffer adverse clinincal results. One must look elsewhere for the root causes of this problem.

Findings as to the Nature and Incidence of Malpractice

Finding 4: It is universally agreed that genuine cases of malpractice occur, and that when they do the victim ought to be compensated. Thus, there is no challenge to the proposition that negligence in the course of the provision of health care services generates a legitimate grievance on the part of the patient and a genuine liability on the part of the health care professional or institution.

Finding 5: Physicians, hospital staff, and other health personnel practice an imperfect and ever-changing art. There will be failures which are not attributable to negligence and which, if compensated, should not be compensated on a negligence theory.

Finding 6: While it is difficult to quantify the incidence of malpractice, many studies have concluded that there are more instances of malpractice than there are claims submitted.

Finding 7: It is universally agreed that there are known incompetent health care professionals practicing in Michigan and that steps can and should be taken to eliminate the threat which such individuals pose to the public.

Finding 8: While it is widely agreed that incompetent professionals are practicing in Michigan today and that such individuals are in part responsible for the injuries that occur to patients, a disproportionate share of malpractice incidents are attributable to a significant minority of professionals who are basically competent and who, in general, provide care of acceptable quality to patients. The best opportunity to reduce the incidence of malpractice, and thus, to reduce the number and cost of malpractice claims, lies in devising methods of helping these providers minimize the number of accidents which occur to their patients.

Finding 9: In general, insurers in this state have engaged in little or no risk management, loss prevention, or quality assurance activities, despite the existence of strong evidence that the potential for malpractice can be reduced by the use of such techniques.

Discussion

The issue of malpractice has to do, in the first instance, with the injury of a patient through the negligence of a provider. The purposes of medical liability pertain directly to the prevention of malpractice and the compensation of its victims. It is important to begin an analysis of medical liability by attempting to gain an understanding of the extent of medical malpractice in Michigan, and to discern its main characteristics.

The nature of malpractice itself makes it difficult to ascertain in a precise way how often it occurs, where it occurs, what kinds of injuries occur, and so on. But several attempts to measure the extent of malpractice have been made over the past several years. These analyses suggest several important conclusions.

First, these studies remind us that there is an important distinction between a bad outcome and a bad outcome which is due to negligence, i.e., between a maloccurrence and malpractice. Not every bad outcome can be avoided, and it is unreasonable for patients to expect only positive results. Further, not every injury which is attributable in some sense to medical intervention (i.e., iatrogenic injuries or diseases) is due to negligence. It is essential for the effective operation of the health care system that these distinctions not be blurred. It seems clear that the system cannot deliver the generally high quality care to which we are accustomed if its practitioners are forced to avoid practices which present risks to the patient. For example, it is well known that many procedures, including certain sophisticated diagnostic and surgical procedures, have associated with them a certain risk of adverse result, even when performed flawlessly. Such a result does not constitute evidence of malpractice, and it is crucial that it not be confused with malpractice.

On the other hand, only a comparatively small proportion of genuine malpractice incidents result in malpractice claims. A federally-sponsored study in 1973 indicated that only 1 in 15 instances of malpractice led to a claim.[2] A 1977 study of hospital records in California suggested that 1 out of 6 incidents of malpractice resulted in a claim.[3] A 1978 study at the University of Southern California indicated that 1 out of 8 malpractice incidents resulted in a claim,[4] while a recent study at the University of North Carolina suggested that as few as 1 in 20 incidents results in a claim.[5] These reports should be interpreted with care, of course, since it is likely that few serious injuries escape the attention of the victim, and since the bulk of unreported cases probably involve injuries with no long-lasting effects, but it is difficult to avoid the conclusion that patients suffer many more injuries than our experience with malpractice claims would suggest. It seems likely that patients are frequently unaware that an adverse clinical event is the result of provider negligence and thus avoidable. It is worth adding that virtually everyone with whom we have consulted in the course of this inquiry, including those who represent physicans and hospitals, has confirmed in a general and anecdotal way that these studies are probably accurate in their general conclusions.

If we accept, in general, the idea that malpractice does occur, and perhaps more frequently than we ordinarily realize, it is natural to consider next how those responsible can be identified.

It appears that providers can be grouped into three categories with respect to this question. First, it is well-known that certain providers are incompetent. It is a matter of common sense to suppose that these individuals make a contribution to the malpractice problem. Second, a disproportionate number of malpractice claims are filed against a relatively small number of providers who, though they are not generally considered to be incompetent, appear to be susceptible, for various reasons, to the commission of errors. And third, a large number of claims are filed against providers who are without question competent and generally considered to render care of adequate quality. It is desirable to discuss each of these categories briefly.

With respect to the first group identified above, it is widely acknowledged that our regulatory system has failed to eliminate known incompetent physicians and other professionals from the health care system. These problems have been well-documented in the press over the past two years[6], and the legislature has already invested a substantial amount of energy in formulating a program to deal with them[7]. Patients are harmed by these individuals at an unacceptable rate, and it is highly likely that some portion of the malpractice problem is attributable to them. It may be, however, that truly incompetent physicians become uninsurable fairly quickly and that their numbers are comparatively small.

The second group identified above, i.e., that group of physicians which accounts for a disproportionately large number of claims, is worth focussing on at some length. Data recently compiled by the Michigan Office of Health

and Medical Affairs suggest that a fairly large share of the malpractice problem involves this group.[8]

In a study involving all claims filed against all physicians between 1976 and 1984 who were insured by the three currently active insurers of physician malpractice in Michigan, data compiled by the Office demonstrate that, both in the aggregate and by specialty, a small though substantial number of physicians account for a large number of claims. The methodology employed was extremely conservative and almost certainly understates this effect. Despite this, the following results emerge. For all claims and all physicians, 0.2% of all physicians accounted for 3.4% of all claims, 2.5% of all physicians accounted for 19.7% of all claims, and 19.3% of all physicians accounted for 72.2% of all claims. Further, 58.1% of all physicians had no claims at all.

One's first reaction to these startling findings is to assume that this reflects the increased likelihood that the comparatively few physicians in the so-called high-risk specialties will have disproportionately more claims lodged against them, and that it is to be expected therefore that most claims will be lodged against a relatively small number of physicians. But this turns out not to be the case. A pattern similar to that described above appears to hold within each specialty, as well as for physicians as a whole.

Thus, for example, among physicians who are in general/family practice and internists who perform no surgery, 0.8% of these physicians accounted for 10.7% of claims and 10.6% of these physicians accounted for 62.9% of claims. Among general surgeons, 5.4% accounted for 20.8% of claims. Among obstetricians, 0.9% of physicians accounted for 5.7% of claims and 8.8% accounted for 30.5% of claims. Among the so-called high-risk specialty physicians, 1.1% of physicians accounted for 6.9% of claims and 11.1% accounted for 40.0 % of claims.

See the Appendix, Tables 1 and 2 for more detail.

These findings seem to point to certain fundamental conclusions with respect to malpractice. While the study focusses only on claims filed, as opposed to closed claims, it seems quite likely that the pattern of filed claims is a reliable rough indiicator of the pattern of claims which have a legitimate basis. To the degree that this is so, there can be little doubt that a very large part of this problem is concentrated in a comparatively small part of the physician community.

In addition, these findings cast doubt on the argument that the present problem is largely a consequence of the growth of "frivolous" claims. If it were the case, for example, that the public has come to regard the medical liability system as a "lottery", then one would expect that the filing of claims would be spread much more evenly among physicians. It is difficult to understand why, if the filing of a claim generally has little to do with the commission of an underlying negligent act, that claims are concentrated against such a small number of physicians. To put the point otherwise, if the filing of claims are

"random" events which are unrelated to the actual incidence of malpractice, why are the claims concentrated in this way?

Finally, these findings are quite significant because they demonstrate that, within both high and low risk specialties, there are specific physicians who tend to be the objects of malpractice claims. While this subject requires a very great deal more investigation, it is possible to hypothesize that most members of this group are physicians who are generally competent, but who are, in some sense, error-prone. Given the large proportion of the claims attributable to this group, it is clear that there is a need to focus carefully on what might be done to deal with this phenomenon.

The third group described above consists mainly of physicians with respect to whom there is no doubt as to their competency and as to the generally high level of care which they take in providing services to patients. It may well be that there is, in practical terms, an irreducible minimum amount of malpractice which we must be prepared to accept and which is to be accounted for in terms of the normal failings of human beings.

To the degree that the present "crisis" is a function of the amount of malpractice which actually occurs, it is possible to make substantial progress towards resolving the "crisis" by reducing the incidence of malpractice. In particular, the second and third of the groups which are identified above, which comprise our supply of competent physicians, would benefit greatly from a serious, sustained effort to identify and remedy those specific behaviors which lead to errors and accidents. Effective techniques for doing this exist.[9]

In this connection, it appears that, with the possible exception of the state's principal malpractice insurer for hospitals, virtually no effort to undertake serious and effective risk management and loss prevention activities has been made in this state.[10] Neither the companies which insure physicians nor the medical community itself has, up to now, seemed to recognize the value of, nor exhibited a willingness to commit the resources to, such an effort. Yet, this as an essential part of the solution to this problem.

Findings As To the Nature, Number, Disposition and Costs of Malpractice Claims

Finding 10: A review of Michigan's malpractice claims experience over the past ten years suggests that the single most important development has been the very substantial increase in the number of malpractice claims.

Finding 11: Such a review further indicates that, over the past ten years, average indemnity payments have increased substantially, but that the trends vary from insurer to insurer and are characterized by large year-to-year changes in both directions.

Finding 12: Over the past ten years, the average cost of defending against a malpractice claim has increased substantially, but the trends vary from insurer to insurer.

Finding 13: The pattern of claims disposition has not changed significantly over the past ten years; though this varies from insurer to insurer, over this period, approximately 40%-50% of all claims were closed with an indemnity payment, while 50%-60% were closed with no indemnity payment.

Finding 14: Processing malpractice claims through the courts on a tort theory is a very expensive and time-consuming way to adjudicate such claims.

Discussion

The cost of malpractice insurance to providers is theoretically determined by the insurer's costs. These costs are in turn determined by the insurer's claims experience: the number of claims, how they are resolved, what sorts of indemnities must be paid, etc. This inquiry has led to the following conclusions with regard to this state's claims experience over the past decade.

First, the principal determinants of premiums are the frequency of claims (i.e., how often they are filed) and the "severity" of the claims (i.e., how much, on average, each claim will cost). There has been much discussion of the relative contribution of these factors to the recent escalation of malpractice inurance premiums. Based on the available data, it appears that the former has been a more important factor than the latter. In general, the frequency of claims has grown by between 50% and 100% over the period from 1976 to 1985. As an illustration, Table 3, Appendix, shows the increase in claims frequency for one of Michigan's domestic insurers.

With respect to the severity of claims, though the average indemnity payment has grown, each insurer's experience has been quite different. While there is a clear overall upward trend for all insurers, the trend of at least one insurer seems to suggest that the worst has past, while in other cases the trend continues upward (see Appendix, Table 4). In addition, this particular factor is surprisingly variable from year to year.

Finally, the average expense associated with a claim (i.e., its investigation and defense) has exhibited a pattern similar to that of indemnity payments. These costs have grown, but they have grown erratically and at a rate which is lower than might be thought when viewed in real (i.e., inflation-adjusted) terms. (See the Appendix, Tables 5).

A further important issue has to do with the disposition of claims. In general, though there have been many more claims in recent years, the proportion of claims which fall into the three main categories of claims disposition (i.e.,

claims which result in neither expenses [i.e., costs of investigating and defending a claim] nor indemnity payments [i.e., payments to claimants]; claims which result in expenses only; and claims which result in both expenses and indemnity payments) have not changed appreciably. Over the past ten years, the proportion of claims resulting in neither indemnity payments nor expenses has held at about 15%. The proportion resulting in expenses only has held at about 40%, and the proportion resulting in both expenses and indemnity payments has held at about 45%. The experience varies, of course, from insurer to insurer.

The combined results of all this are fairly obvious. The substantial growth of indemnity payments and expenses, along with the very rapidly growing number of claims and the relatively constant claims disposition pattern, has led to a large increase in the number and cost of successful claims.

This inquiry thus confirms what has been generally accepted with regard to the basic trends of malpractice claims.

Discussions of our claims experience often come around to the question of "frivolous" claims, which is generally intended to refer to claims which are without merit. "Merit", however, is in the eye of the beholder. Whether or not negligence was present, a bad clinical result may leave the patient and/or the family angry and frustrated. The filing of a malpractice claim under such circumstances suggests that the liability system often serves as a outlet for expressions of dissatisfaction with the health care system. Thus, the claim may be without merit when viewed through the window of negligence, but may be entirely understandable in terms of human experience.

Further, the inherent limitations of a patient's ability to apprehend the complex technical facts of the care which he or she has received complicate the patient's ability to distinguish between a maloccurrence and malpractice. Judging the preventability of a clinical injury is not the same as knowing whether one's car has been damaged in a parking lot collision. Given the nature of medical care, one would expect the "gray area" which separates malpractice from maloccurrence to be hard to define, and that a patient will often use the device which society has provided, i.e., the courts, to find out which of the two categories his or her particular experience falls into.

The legal expenses and time-consuming nature of the present system warrants at least a brief discussion. An insurer's aggregate costs of investigation and defense appear to average between a fourth and a third of aggregate indemnity payments. Thus, for example, if total indemnities paid in a given year by a given insurer were $20,000,000, one would expect total expenses to be in the range of $5,000,000 to $7,000,000. If, for the purposes of this discussion, it is assumed that a third of paid indemnities are paid to plaintiff attorneys under contingency arrangements, one could conclude that, of the $25,000,000 to $27,000,000 paid out by that insurer in that year, between $11,500,000 and $13,500,000 would go for legal and related

expenses. That is, between 45% and 55% of total payments would go to parties other than successful plaintiffs.

An example of this sort illustrates the urgency of the need for an inquiry into the possibility that other, more efficient systems of handling malpractice claims can be devised.

As to the length of time which is currently required to close a claim, it will be sufficient to recite, as an example, the experience of one of our domestic malpractice insurers.[11] Over the period from 1976 to 1984, fewer than 20% of claims were closed within two years of filing and only 55% were closed within four years of filing. These figures illustrate the extraordinarily long periods required to settle which have evidently now become typical. This once again points to the need to investigate whether there might be a better way to deal with these claims.

Findings As To The Cost and Availability of Malpractice Insurance

Finding 15: For physicians, between 1976 and 1985, malpractice insurance premiums charged by the majority of insurers did not generally increase in real (i.e., inflation-adjusted) terms. In fact, within most specialties, the inflation-adjusted costs of malpractice premiums for most physicians decreased, in some cases substantially.

Finding 16: For the majority of insurers, the trend in physician premiums shows that between 1976 and 1982, premiums declined by about half in real terms. Between 1982 and 1985, premiums increased dramatically, so that, in real terms, 1985 levels are generally at or slightly below 1976 levels.

Finding 17: The experience of hospitals has mirrored that of physicians. That is, premiums declined sharply between 1976 and 1981, and increased between 1982 and 1984, and increased significantly between 1984 and 1985. As with physician premiums, an analysis of premiums in real (i.e., inflation-adjusted) terms shows that 1985 premiums are roughly equal to 1976 premiums.

Finding 18: Malpractice insurance premiums have exhibited an extreme volatility, despite what appears in retrospect to have been a fairly clear and consistent set of trends in the underlying determinants of the premiums.

Finding 19: Large-scale economic variables, such as interest rates and liability insurance industry cycles appear to have played a substantial but limited role in the setting of premiums over the past decade.

Finding 20: In general, malpractice insurance remains available. Policies with certain very high limits appear to be increasingly difficult to obtain, but there is little evidence of widespread availability problems.

Discussion

There is no question but that malpractice insurance premiums have increased dramatically in the recent past. It is worthwhile, however, to examine these rate increases in a broader context. A review of premium trends for a large sample of physician specialties and for hospitals shows that, in inflation-adjusted terms, 1985 premium levels are generally equal to or slightly less than those of 1976. (See Appendix, Tables 6-11). These trends have not been smooth, however. Premiums declined steeply in the latter half of the 1970's, bottomed out in 1982, and began rising rapidly thereafter.

These trends warrant at least a brief discussion, since it has been the reaction of the provider community to these premiums that has largely generated the current legislative interest in this issue. Further, though the science of insurance ratemaking is an arcane one, and though this report is unlikely to shed any new light on these matters, the following comments seem in order.

The first thing to say about these trends is that are not confined to medical malpractice insurance, to Michigan, or even to the United States. It is well known that rates have increased dramatically and universally for almost all forms of liability coverage. This suggests that what happened here is at least partly due to larger forces that are likely beyond our control. Thus, for example, interest rates play an important, but limited, role in ratemaking. It is generally possible to reconstruct the ratemaking activities of the past, and it appears both that interest rates were taken into account in a systematic way, and that their specific influence on rates is discernable and quantifiable from the actuarial analyses supporting the rates.[12]

Second, viewed in broad terms, it is not surprising that the overall trend in these rates is upward, given the corresponding trends in the underlying determinants of the premiums, i.e., the claims experience. What does need explaining, however, is the volatility of these rates. It seems reasonable to suppose that if these rates had increased gradually and incrementally over the past decade, as the claims experience would seem to have required, then those providers who have been confronted with the large premium increases of the recent past would be far less concerned, though not indifferent, to the situation.

On this point, it appears that the volatility of rates is to some degree explainable in terms of four principal factors. The first factor has to do with the basic underlying determinants of premiums, i.e., expected losses and expenses. Based on a preliminary examinationof the issue, it appears that the actuarial analyses supporting the rates developed in the late 1970's and early 1980's failed to fully anticipate the growth in claims filed and the growth in indemnities. This appears to have exerted an inappropropriate downward pressure on premiums. Second, the extremely high interest rates of the late 1970's and early 1980's apparently permitted insurers to cut back premiums because of increased investment earnings. Third, the market for malpractice

insurance during this time period appears to have been characterized by aggressive price-related competition among the insurers, most of whom were new companies at that time and who were energetically attempting to maximize their market shares. This also had the effect of putting downward pressure on premiums. Finally, in the past two to three years, the combined effects of declining interest rates, the past underestimation of future losses, and the increasingly worrisome outlook for losses beyond 1985 appears to have brought about the steep recent increases.

Whether or not this type of behavior on the part of the insurers constitutes sound business management is a question to which an answer shall not be supplied here. See the discussion pertaining to Recommendation 11.

As to the question of the availability of malpractice insurance, there has been little evidence that providers cannot obtain primary coverage in reasonable amounts, though it is undoubtedly true that some providers in need of policies with unusually high limits may be encountering difficulty. If a more widespread problem exists, its scope and magnitude have not yet become apparent.

III. RECOMMENDATIONS

Introduction

Based on the facts described above, a review of the literature with respect to similar problems in other states, and discussions with a large number of knowledgeable people, I draw these conclusions as to the malpractice problem:

First, the "crisis" is not one for the doctors, the hospitals, the insurance companies, and the lawyers. Rather, it is a crisis for all of us because it poses risks to the basic underlying structure of the health care system. The principal threat appears to be that of the growing inclination on the part of both providers and patients to regard each other with suspicion and distrust.

An important but subsidiary problem has to do with the costs of malpractice and the costs of health care. We have long known that the cost of health care is one of our most serious problems, and that unless we learn to cope with it, we shall some day face the prospect that our standards of care will begin to deteriorate. While it is difficult to say with precision how much of the health care cost problem is attributable to malpractice costs, the contribution of these costs is clearly more than negligible.

Finally, there is no question but that certain individual providers find themselves under extraordinarily severe financial burdens as a result of recent premium increases. In many of these cases, relief is both needed and appropriate.

We all have a stake in the outcome of this problem. The question is whether we have the will to take the steps which are necessary to bring about the desired changes. There is little hope of success if each group within our society takes a narrow and parochial view of the issue.

Second, mere revisions in the tort law, though susceptible to quick action and perhaps capable of providing some temporary relief, will not stabilize malpractice insurance rates over a period of time.

Third, the best hope for a solution lies with a multifaceted approach that incorporates both short- and long-term measures. In the short-term, I believe that it would be desirable to provide some form of immediate rate relief for providers, to enact certain tort reforms, to create certain new insurance mechanisms, and to enact certain widely agreed-upon improvements to the state's disciplinary system for providers.

With respect to the long-term, promising opportunities for success lie along the following paths:

1) The development of a major new program to reduce, and, if possible, eliminate incidents of malpractice through a much-expanded system of state-sponsored professional self-regulation, and through the development of new risk management and loss prevention initiatives.

2) The further development of the arbitration plan which the legislature enacted in the mid-1970's for offering methods other than litigation for resolving malpractice disputes. The implementation of this legislation was slow in gathering momemtum because of constitutional challenges to its validity which were recently resolved. There are other possible approaches being used in other jurisdictions which might be used in addition to the arbitration and mediation services now available. It is essential that those approaches be explored for whatever help they may offer.

3) The careful examination of malpractice insurance company practices, including actuarial techniques, the establishment of reserves, and in particular, the development of rating classifications.

4) A careful study of the so-called no fault options for malpractice insurance. Such a study should not neccesarily have as its objective the adoption of such a system, but should at minimum help us to determine the state of the thinking on the subject, what approaches are available, and what benefits, if any, they offer. It would be unwise to conclude without any study that some system of what is popularly called "no-fault" insurance is impossible for malpractice, or that it could not be reformulated to become possible.

Finally, I see little hope that any of these approaches will be successful unless they result from a cooperative endeavor between the government and the various private individuals and organizations which must make them work.

With this introduction, I set forth the following specific recommendations.

General recommendations

Recommendation 1: The development and implementation of measures to resolve the malpractice problem should be divided into two phases. Phase I consists of a series of actions which can and should be taken immediately. These actions are set forth in Recommendations 3 through 7. Phase II consists of a series of steps which cannot be undertaken without extensive preparation in early 1986. These actions are set forth in Recommendations 8 through 13.

Recommendation 2: Given the interrelationships between the elements of Phase I and those of Phase II, it is essential that the implementation of these recommendations be overseen and coordinated by a single individual or entity, designated by the Governor for this purpose.

Recommendations for Phase I: Immediate Actions

Recommendation 3: The legislature should enact a package of tort reforms including the following elements: revision of the doctrine of joint and several liability; adjustment of the collateral source rule; mandating the use of structured awards; adjustment of the statute pertaining to pre-judgment interest; the creation of statutory authority for the assignment of costs in frivolous actions; and refinements to the statute of limitations.

Though these reforms should be made effective immediately, they should expire by June 30, 1986 unless the governor certifies to the legislature prior to that date that, by various legislative, administrative and private means, the following have been achieved: the enactment of an expanded state system for assuring the competency of providers, and the design and implementation of effective insurer-sponsored programs of risk management and loss prevention. See Recommendations 8 and 9.

Recommendation 4: The legislature should decline to enact the following tort reform proposals: the qualification of expert witnesses; the mandatory use of pre-trial screening panels; and a limit on non-economic damages.

Recommendation 5: The legislature should create a state-administered Medical Liability Fund. The Fund would be the source of payment for selected awards. Possible cases for payment out of this Fund would be all those in which a claim is asserted more than a certain number of years after its occurrence, provided the claim is valid under the statute of limitations, and that portion of all awards against physicians in excess of some dollar threshhold. The Fund would be financed by a flat annual assessment on all licensed physicians.

Use of the Fund should commence on July 1, 1986, provided that the Governor certifies to the legislature by that date that, by various legislative, administative, and private means, the following have been achieved: the enactment of an expanded state system for assuring the competency of providers, and the design and implementation of effective insurer-sponsored programs of risk management and loss prevention. See Recommendations 8 and 9.

Recommendation 6: Malpractice insurance premiums should be frozen at their December 1, 1985 levels until June 30, 1986. Such a freeze should be undertaken voluntarily by malpractice insurers, but, if necessary, should be achieved by appropriate legislative or administrative means.

Recommendation 7: The legislature should enact a set of measures roughly along the lines of those which have been incorporated into the

proposals of both houses pertaining to the strengthening of the state's disciplinary system.

Recommendations for Phase II: Actions in 1986

Recommendation 8: Beginning immediately, and continuing through the first half of 1986, the Governor's Designated Representative should supervise the development of a major expansion of the system by which the competency of providers is evaluated and maintained. Such an effort should involve, at a minimum, the state officials responsible for the licensing and regulation of providers and the professional organizations which represent the state's providers.

This effort should be aimed at the enactment of such an expanded system by June 30, 1986, so that the Governor can make the appropriate certifications to the legislature as described in Recommendations 3 and 5.

Recommendation 9: Beginning immediately, and continuing through the first half of 1986, the Governor's Designated Representative should supervise the development of insurer-sponsored risk management and loss prevention programs. Such an effort should involve, at minimum, the state's malpractice insurers, the professional organizations which represent the state's providers, and the state's insurance officials.

This effort should be aimed at the implementation of such programs by July 1, 1986, so that the Governor can make the appropriate certifications to the legislature as described in Recommendations 3 and 5.

Recommendation 10: Beginning immediately, and continuing through the first half of 1986, the Governor's Designated Representative should supervise the development of alternative systems of rate classifications for physicians for the purpose of narrowing the wide differences in premiums paid by the lowest and highest risk classes. This effort should involve the state's malpractice insurers, professional organizations representing the state's providers, and the state's insurance officials.

Beginning July 1, 1986, the Insurance Commissioner should, with respect to liability insurance for physicians, require the use of an alternative system of rate classifications.

Recommendation 11: The Governor's Designated Representative should arrange for and supervise an investigation of the practices of malpractice insurers for the purpose of ascertaining whether the performance of these insurers has, in the past, been satisfactory with respect to the manner in which premiums have been set, the manner in which reserves have been established, and other related issues. In addition, an assessment should be made as to whether the current level of state regulation and supervision is

sufficient for the future. This investigation should be completed no later than June 30, 1986.

Recommendation 12: The Governor's Designated Representative should supervise an examination of the various alternative methods of dispute resolution which might make the medical liability system less costly and more efficient. The results of this inquiry should be supplied to the legislature not later than July 1, 1986.

Recommendation 13: The Governor's Designated Representative should arrange for and supervise a study of the potential benefits of a "no-fault" system of malpractice insurance. Such a study should be completed by January 1, 1987.

Discussion

There are three essential ingredients in carrying out the program which I have here proposed. One is that it must be done in two phases, the first of which would be immediate, and the other to require much of 1986 to complete. The second essential ingredient is that though portions of the program would be carried out in 1985, and other portions in 1986, they must be inextricably interlocked so that they become a package. The third is that the relationships between the two phases are such that the success of the overall program depends heavily upon careful coordination of its various elements.

The principal reason for suggesting that this program be undertaken in two parts is straightforward: I do not believe that the necessary preparation for much of it can be completed within the next few days and weeks. On the other hand, some of the measures which I here recommend have already been given significant study and can go forward without delay. Therefore, I propose dividing the program into two parts, enacting what can be enacted at this time, and taking up the remainder next year.

As to the question of linking Phases I and II, it is apparent that the implementation of these recommendations will require the cooperation of diverse interest groups. Because of this, it is desirable to create incentives for everyone concerned which are sufficient to guarantee that good faith efforts will be made over the entire period of the program's development. The linkages which have been outlined will accomplish this.

As to the matter of the program's coordination, it is obvious that some central individual or entity will need to exercise general supervision of the program's development in order to ensure that its underlying logic is preserved.

Phase 1

Phase I consists of five actions which are described in Recommendations 3 through 7. I wish to briefly discuss these here.

In Recommendations 3 and 4, I suggest a set of tort reforms which I believe would not be unfair to either plaintiffs or defendants and which would help to bring about some stabilization of costs. These are as follows.

With respect to the doctrine of joint and several liability, it is patently unfair to hold a defendant who bears less than total degree of responsibility for negligence in a malpractice suit liable for the entire amount of the award. If each defendant assumes liability for the degree of fault attributed to him by the finder of fact, and a like responsibility for the share of an insolvent defendant up to a total of 80% of the total award, the result would seem more equitable.

As to the collateral source rule, if the claimant will recover damages from other sources, this information should be available to the jury in making its award. Insofar as this collateral recovery has been financed by payments from the claimant, such payments should obviously be deducted from the amount considered to have been received from the collateral source.

The structured payment of awards (i.e., the payment of awards in increments payable at specified intervals) is reported to be in use in Michigan courts today. If the legislature simply mandated the use of structured payments where feasible and fair in the circumstances of the case, most of the advantages of using such awards would be preserved while at the same time avoiding inequities. In addition, it is obvious that expenses already incurred and medical expenses, which may accrue in lumps, must be treated differently.

With respect to pre-judgment interest, allowing interest rates to accrue at a fixed rate prior to judgment is inequitable in view of market fluctuations in the interest rate. The rate should therefore be tied to some index. Trying to tailor the interest rate to create an equal incentive to the plaintiff and the defendant to settle cases appears to achieve erratic results and should not be attempted.

Michigan Court Rules already provide for the use of various tactics in dealing with "frivolous" cases. There is thus nothing inherently unfair in assigning costs, including attorney's fees, against the claimant or defendant and their attorneys when a frivolous claim or defense is asserted.

The statute of limitations might well be improved by refining the manner in which the statute treats the question of when an incident has occurred. However, it is clearly unfair to disallow a claim which could not have been asserted because evidence of its existence had not yet become apparent, and I would be opposed to any absolute limit on the right to bring such an

action. (In connection with this issue, I direct the reader's attention to the discussion of Recommendation 5.)

I believe that the collective effect of these measures will be positive, though limited. The evidence on this point, while mixed, suggests that they may well diminish the costs of awards and more equitably distribute the burden of paying them.

In Recommendation 4, I address three items which have been prominently mentioned as a part of the tort reform package, but which I suggest be omitted from the group of Phase I actions. Though I recommend that these not be adopted at this time, I am not prepared to say that one or more of them could not be made workable. If no other way to resolve this problem can be found, they may well have to be considered at a later date. They are: the qualification of expert witnesses; pre-trial screening panels; and a limit on non-economic damages.

When the figures show that between 80% and 90% of malpractice cases tried before juries result in no award, it is difficult to conclude that juries cannot tell the difference between an expert and an inexpert witness when they are on the stand. It is to the clear advantage of the lawyer to use the best and most credible witnesses and inexpert witnesses are not usually difficult to expose. For this reason, when one weighs the advantages of mandating the degree of experience required of a witness versus allowing the judge to rule on whether a given witness can qualify as an expert, the virtue of a new requirement is not readily apparent.

On the matter of pre-trial screening panels, there is by now a good deal of experience with their use in other states. The results are generally mixed, with some state's having had success while others have not. There is, at minimum, the danger that such a procedure would result in two trials rather than one, for if the panel is influential (e.g., if the panel's conclusions are to be admitted in court), counsel for both sides will be inclined to put a major part of their effort into the appearance before a panel. On the other hand, if the panel is not likely to be influential, there is no reason to have it in the first place. On balance, the value of the screening panel is thus not established, at least in all cases.

There may well be some variation on this theme that would have merit. The many positive advances in dispute management which have emerged from work in other fields could well lead to some effective formulation of this idea. An inquiry along this line would be part of what is suggested in Recommendation 12.

Finally, and most contentious of all, is the proposed cap on non-economic awards. Some lawyers will argue that this is unconstitutional in any event, but state supreme courts are in conflict on that issue. The most powerful current precedent comes from the State of California, where its Supreme Court ruled in *Fein v. Permanente Medical Group*, 38 Cal. 3d 137 (1985) that the state's

$250,000 limitation in medical malpractice actions for "non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other non-pecuniary damage" was a rational response to the problem of rising malpractice insurance costs. The U.S. Supreme Court has recently dismissed an appeal of this case for want of a substantial federal question.

My own hesitancy in endorsing a limitation on damages does not arise out of constitutional concerns, but out of a conviction that this approach should be regarded as a measure of last resort. If a solution which addresses the fundamental cost problems associated with malpractice can be developed along the lines which have been proposed, then a limitation may be unnecessary. If this proves not to be the case, a limitation can be considered.

In Recommendation 5, I have proposed the creation of a state-administered Medical Liability Fund to be financed by a flat annual assessment on physicians. The assessment each year would be determined by the Fund's expenses, and the Fund would thus be financed on a "pay as you go" basis. There are two possible uses for this Fund. First, insurers face genuine difficulties in setting rates and reserves when cases which are 10 or 15 years old may emerge without warning. Though these cases are often legitimate, it may be asking too much to expect stable rates under these circumstances. As a way of responding to this, payments of settlements and awards for cases in which a claim is asserted more than a certain number of years after its occurrence could come from this Fund. Under this arrangement, the Fund would act as the primary insurer and would be responsible for any defense which is mounted against the claim. This proposal would have two desirable effects. It would have the direct effect of limiting the period of time for which a commercial insurer would be responsible for an insured. The insurer would thus have a fixed period of time over which claims, indemnities, and expenses would have to be projected, and we could expect a significant improvement in the stablity of rates. In addition, it would have the indirect effect, given the manner in which it is to be financed, of spreading the risk for these cases over the entire physician community. (See the discussion below of Recommendation 10.) The point at which claims would be become eligible for payment from the Fund should be determined in the course of the development of the enabling legislation, and in consultation with the affected parties; for purposes of this discussion, it is sufficient to think of the Fund as the exclusive source of payment for so-called "long tail" cases.

The second purpose of the Fund could be to finance the portion of awards against physicians in excess of a certain dollar threshhold. With respect to this function, the Fund would act as a mandatory statewide provider of non-primary or excess coverage. There is good reason to indemnify physicians against total financial destruction through a malpractice award. Again, since this would be financed by a flat rate assessment on physicians, it would tend to spread the risk more evenly than is now the case. As with the first function of the Fund described above, the dollar threshhold above which the Fund would assume financial responsibility should be determined as part of the

develpment of the Fund's enabling legislation. In general, however, the threshhold should not be so low as to preclude the need for commercial primary coverage, nor should it be so high as to fail to provide substantial protection.

Though this Fund is not presently envisioned to include other providers, that could easily be done if a reason for doing so were identified.

In Recommendation 6, I have proposed a freeze on all malpractice insurance premiums at their levels of December 1, 1985 through June 30, 1986. I suggest this for the following reason. The various tasks which I set out in Phase II will require a series of serious and delicate negotiations among the parties. Such negotiations cannot take place if disruptive events, such as a major increase in premiums, occurs while they are underway. Further, the state of excitation and concern among providers over this issue is such that a "cooling off" period is highly desirable and will greatly enhance the prospects for meaningful and constructive discussions over the next few months.

Recommendation 7 urges the adoption of legislation with respect to which there now appears to be wide agreement and which would help to eliminate the most incompetent providers from the health care system. Two comments seem in order here. First, though this report has reconfirmed the need to take action in this area, it remains important to fulfill our obligation to provide due process to those against whom action is comtemplated. Second, above all else, it is necessary to provide protection from liability for those citizens who, as volunteers, participate in the process by which the profession oversees and acts against incompetent providers. Beyond this, I shall not discuss these bills other than to say that they should be enacted irrespective of the malpractice situation.

Phase II

Phase II consists of six actions which are described in Recommendations 8 through 13. I discuss these below.

Recommendations 8 and 9 propose that, under the supervision of the Governor's Designated Representative, an effort be undertaken to develop a very much enhanced State-sponsored system for assuring and maintaining the competency of providers in Michigan and to develop serious insurer-sponsored risk management and loss prevention programs. Simple logic tells us that if the number of incidents of malpractice could be reduced, it would go a long way toward resolving the present difficulty. Our findings have illustrated the need for an improved system of monitoring the performance of providers and for taking appropriate disciplinary and/or remedial action when necessary. How best to accomplish this is of course a difficult question.

In Recommendation 7, I endorse the enactment of the proposals which have already been formulated by the legislature for the purpose of strengthening the state's regulatory and disciplinary system. However, it is widely agreed that, without a major expansion of its scope, authority, and resources, the state's regulatory and disciplinary system will continue to focus on that small group of providers who constitute the most serious danger to the public health.

As stated previously, the most significant part of the malpractice problem lies with a group of physicians who, though they comprise a minority of all physicians, nevertheless include a large number of individuals. Finding a way to deal with these providers requires that the state move beyond the present system.

In responding to this problem, it would be ideal to involve both the relevant government agencies and the professions themselves, each of whom have expressed a desire and a willingness to get on with this job.

But in setting out to devise a new, improved approach to this problem, it is crucial to keep one point in mind. This is not simply a "bad apple" problem. A large part of the problem involves basically competent providers who, for various reasons, tend more than most to be involved in accidents. These are individuals who probably should not be prohibited from practice, but who need careful watching and assistance in avoiding accidents.

This point has important implications for the overall objective. Rather than devise a system which is focussed on the identification of the least competent provider, a ay must be found to enhance the type of monitoring to which all providers are subject, and to make available to those who need assistance the appropriate kinds of help.

By way of illustration, it is not difficult to envision a system in which the state would greatly expand the scope and visibility of its regulatory activities related to assuring the competency of providers. For example, the state might establish a large number of local, provider-sponsored quality assurance entities which would operate under the guidance and control of the state and which would conduct continuous, intensive peer review activities. These might include routine and random examination of a provider's medical records, "site visits" in which the provider's handling of patients was observed first hand, and many other activities. Such entities might involve county medical societies, the state's medical schools, and others. The entities might be required to supply the results of their reviews to the state regulatory authority along with recommendations for corrective action, which might include, for example, prohibiting a provider from engaging in a specific procedure until additional training was obtained, etc.

In general, the obstacles to the development of a much more effective quality assurance program are not technological. It seems much more likely that the obstacles in the past have had to do with the natural tendency of the

professions to resist what they may have believed to be excessive and unnecessary oversight. Even if this was once the case, it is no longer. The debate on malpractice has created an opportunity to make significant progress in this area, and all parties may now be willing to attend seriously to this issue. Under the guidance of the Governor's Designated Representative, and with the assistance of the state's regulatory officials and the professional associations, it should be possible to devise an innovative and effective approach to this that will lead to great improvements in this area.

With respect to risk management and loss prevention, we know that in other fields of liability insurance, the role and value of these kinds of activities are well established. In fact, there is considerable evidence that they can be of value in this field as well, and we should insist that it be taken more seriously in the future. There is no reason why insurers should not require physicians to spend whatever time is required to become aware of the specific practices that lead to accidents and malpractice claims based on those accidents. Thus, for example, it seems reasonable that physicians of each specialty should be continuously advised of the leading causes of malpractice claims against the specialty and how these might be avoided. As for the insurers themselves, should not be required to invest whatever resources are required to identify the kinds of incidents that lead to malpractice claims, to determine how they happened, and to see how they might have been prevented?

Recommendation 10 proposes the development and implementation of alternative rate classification schemes for physicians. The current practice of dividing physicians into as many as eight classes for rating purposes is undesirable and should be abandoned. Such a practice has, first, the effect of speading very great risks over comparatively small numbers of physicians in the higher risk classes. But, more fundamentally, such a scheme overlooks the deep interconnections among physicians within the health care system. In the modern system, all physicians are highly dependent on their colleagues, and the care of patients has become the responsiblity of networks of physicians who collectively possess the required skills and knowledge. Finally, such a scheme too readily brings to the surface the types of financial crises which many physicians are presently experiencing. An alternative scheme would result in a malpractice insurance system with significantly greater depth, flexibility, and capacities to withstand the sorts of difficulties it is currently encountering.

In Recommendation 11, I propose that an investigation be undertaken of the practices of the malpractice insurers. Though my preliminary look at this situation leads me to conclude that, by and large, things are generally in order, further inquiry is warranted. There has been repeated criticism of the liability insurance industry on the ground that financial analysts continue to tout such companies as good investment opportunities at the same time that the companies seek significant rate increases on the basis of financial need. While the data necessary to conduct this investigation are available, we have not had the time and the resources to analyze it. In addition, it is important to

review whether the type and amount of state regulation to which these insurers are subject is sufficient.

Recommendation 12 proposes an inquiry into the question of whether it is possible to devise better systems than we have presently to deal with some or all malpractice cases.

There is clearly widespread dissatisfaction with the present system of adjudicating health care malpractice cases. This was undoubtedly the reason that the legislature enacted the arbitration program for malpractice in 1976. It was designed to simplify the process of adjudication, reduce the time required to process the complaints, substantially reduce costs for both claimaint and defendant, and at the same time produce both a fair and equitable result. The program has not yet had a fair chance to prove its value because it was under constitutional attack until 1984. Now that the legislation has been upheld by the Michigan Supreme Court, there is every reason to suppose that it will prove its usefulness.

Meanwhile, both federal and state courts are plagued with heavy case loads, causing the Chief Justice of the United States and the American Bar Association, as well as many other organizations, to endorse and support innovative alternative methods for dealing with a wide variety of disputes. Included in this category are new types of mediation, mandatory non-binding arbitration, and the mini-trial, which might have particular application to malpractice cases now going to trial. Detailed discussions of these many approaches are widely available in the literature.[13]

Still other approaches speak directly to the health care malpractice problem. The Michigan Department of Public Health, under the direction of Dr. Gloria Smith, has prepared a proposal for systemic reform in the adjudication of malpractice cases. The proposal offers a "trade-off between uninhibited access to the courts for the relative few who use them versus much more broadly accessible mechanisms for surer, smoother, and faster protection of patients and tougher, more systematic sanctioning of providers".[14] This proposal deserves serious consideration.

Another formula for dealing with health care malpractice in a new and different way is contained in the so-called Moore-Gephardt bill (99th Congress, lst Session, H. R. 3084) now pending before several committees of the Congress. Described as an "alternative liability system for medical malpractice in the case of injuries under medicare and other Federal programs if States fail to provide for alternative liability systems", the law would encourage hospitals and physicians to compensate the patient for his or her net economic loss suffered because of adverse results from treatment. In exchange for the agreement to pay for economic loss, the patient would relinquish the ability to sue for non-economic loss. Tort actions would be preserved if an offer was not timely made, or in certain exceptional cases.

These possibilities are not mentioned for the purpose of endorsing any of them, but to demonstrate that a great deal of thinking is going on with respect to alternatives to the present system, and to suggest that it should be a critical part of Phase II to examine alternatives to the present system. As with other elements of Phase II, the work should be done under the guidance of the Governor's Designated Representative and should involve the insurers, the Bar, the provider organizations, and consumer representatives. This group should attempt to sort out the most appealing possibilities and then identify two or three of them which would seem to warrant wider discussion. Out of this might then grow support for action which could be taken by administrative and/or legislative means.

Recommendation 13 addresses the issue of the applicability of the "no-fault" concept to malpractice. There is no doubt that there are serious inadequacies in a liability plan that pays off only if negligence on the part of the provider can be shown. As at least two observers have noted,

> two different people may sustain an indentical injury and be equally innocent of its cause, and yet their prospects for receiving damages may be entirely different. Eligibility for compensation is determined by the behavior of the person responsible for the injury; so if negligence is present in one case and not in the other, one person will be compensated, and the other will not.[15]

Our sympathies may be just as great in a maloccurrence case as in a malpractice case, and the need of the patient may be just as great. Moreover, in the words of two critics of the present system:

> It is difficult to prove fault in any personal injury case, but the....task of determining whether an adverse result in the course of health care resulted from negligence - and whether the negligent party was the physician, hospital, drug manufacturer, equipment manufacturer, or any of a multitude of others who participate in providing health care (is infinitely more difficult)."[16]

Quite apart from the merits of a no-fault scheme, there have always been major concerns about the cost of such a plan. It seems likely that it cannot be financed by private insurance, and it may well involve government support derived from taxpayers. One way of coping with the cost problem would be to limit the coverage of the plan. In Sweden, where there is in place a Patient No-Fault Insurance plan, the plan does not compensate for all medical injuries but for those that are unexpected for the patient, and unforeseeable or improbable in the judgement of the attending physician. Where an injury is a predictable result or risk of a medical encounter, e.g., the consequence of necessary treatment, it is not compensated. Minor injuries are excluded. If the injury could have been prevented, indemnity is provided.[17]

Since Sweden has a population which is not very different than that found in the State of Michigan (8.3 million vs. 9.1 million), and there is reported to be general satisfaction with their system, it is presumably possible to sustain a no-fault sytem if it is conducted within certain stated limitations.

The point of citing the difficulties in treating adverse medical results purely in terms of negligence, and of citing the Swedish experience, is not to endorse this approach as compared with others. It is merely to say that a great many thoughtful people believe that we must devise a different system than the one we have now. In reviewing the available options, logic argues for the inclusion of a careful analysis of possible no-fault systems.

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1 See, for example, Schwartz, W.B. and Komesar, N.K.. "Doctors, Damages, and Deterrence", New England Journal of Medicine, Vol. 298, No. 23, pp. 1282-1289, 1978; or Bovbjerg, R.R. and Havighurst, C.C., "Medical Malpractice: An Update for Noncombatants", Business and Health, Vol. 2, No. 9, pp. 38-42, Sept., 1985.

2 Pocincki, L.S., Dogger, S.J., and Schwartz, B.P., "The Incidence of Iatrogenic Injuries", Appendix, Report of the Secretary's Commission on Medical Malpractice, Department of Health, Education, and Welfare, 1973, pp. 50-70.

3 California Medical Association, California Hospital Association, Report on the Medical Insurance Feasibility Study, San Francisco, Sutter Publications, 1977; cited in Schwartz and Komesar.

4 Reported in Schwartz and Komesar, p.39.

5 Reported in Michigan Department of Public Health, "Medical Malpractice: A Proposal for Systemic Reform in Quality Assurance, Compensation, and Adjudication", October 23, 1985, pp. 10-11.

6 Detroit Free Press, "Bad Doctors", April, 1984.

7 Report of the Michigan House of Representatives Special Committee on Medical Licensure, December 1984.

8 Michigan Office of Health and Medical Affairs, unpublished data, December, 1985.

9 See, for example, Robertson, W.O., Medical Malpractice, A Preventive Approach, University of Washington Press, Seattle, 1985.

10 PICOM Response to Questionnaire from the House Insurance Subcommittee on Medical Malpractice: Questions for Insurers, October 1, 1985, p. 9; Michigan Physicians Mutual Liability Insurance Company Response to Questionnaire from the House Insurance Subcommittee on Medical Malpractice: Questions for Insurers, Response to Question 30; Medical Protective Company Response to Questionnaire from the House Insurance Subcommittee on Medical Malpractice: Questions for Insurers, October 29, 1985, p. 3; Michigan Hospital Association Mutual Insurance Company Response to Questionnaire for the House Insurance Subcommittee on Medical Malpractice: Questions for Insurers, Response to Question 30 and Exhibit V.

11 PICOM Response to Questionnaire of the House Insurance Subcommittee on Medical Malpractice: Questions for Insurers, October 1, 1985, Exhibit L.

12 See, for example, Milliman and Robertson, Physicians Insurance Company of Michigan Actuarial Rate Level Indications for February 1, 1985, December 20, 1984, Pasadena, California.

13 See, for example, Center for Public Resources, Corporate Dispute Management-1982, Matthew Bender, New York, 1982.

14 Michigan Department of Public Health.

15 Schwartz and Komesar, p. 1282.

[16] Moore, H. and O'Connell, J., "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss", 44 La. Law Review , 1267-1268, 1984.

[17] Private communication, Dr. Marilyn M. Rosenthal, University of Michigan - Dearborn, who is currently engaged in a study of the Swedish system.

APPENDIX

TABLE 1

OHMA 12-12-85

NUMBER OF DOCTORS WITH ONE OR MORE CLAIMS BETWEEN 1976 AND 1984 AND THE NUMBER OF CLAIMS AGAINST THEM
BY SPECIALTY AND TYPE OF DOCTOR FOR THE THREE MAJOR INSURANCE COMPANIES

SPECIALTIES	NUMBER OF POLICIES WRITTEN: '76-'84 number	percent	NUMBER OF DOCTORS* polices/6	DOCTORS WITH ONE OR MORE CLAIMS** number	percent***	DOCTORS WITH 10-17 CLAIMS number	percent	DOCTORS WITH 5 TO 9 CLAIMS number	percent	DOCTORS WITH 2 TO 4 CLAIMS number	percent	DOCTORS WITH ONE CLAIM number	percent	DOCTORS WITH NO CLAIMS number	percent
g.p./medical specialties	52056	63.0%	8676	2405	27.7%	5	0.1%	63	0.7%	855	9.9%	1482	17.1%	6271	72.3
minor surgery	7494	9.1%	1249	608	48.7%	1	0.1%	23	1.8%	247	19.8%	337	27.0%	641	51.3
surgery	9620	11.6%	1603	1324	82.6%	11	0.7%	75	4.7%	583	36.4%	655	40.9%	279	17.4
ob-gynecology	5368	6.5%	895	673	75.2%	8	0.9%	71	7.9%	326	36.4%	268	30.0%	222	24.8
hi-risk specialties	4469	5.4%	745	500	67.1%	8	1.1%	75	10.1%	231	31.0%	186	25.0%	245	32.9
anesthesia	3685	4.5%	614	259	42.2%	0	0.0%	3	0.5%	77	12.5%	179	29.1%	355	57.8
TOTAL	82692	100.0%	13782	5769	41.9%	33	0.2%	310	2.2%	2319	16.8%	3107	22.5%	8013	58.1
TYPE OF DOCTOR															
M.D.	71166	86.1%	11861	4817	83.5%	14	0.1%	204	1.7%	1885	15.9%	2714	22.9%	7044	59.4
D.O.	11526	13.9%	1921	952	16.5%	19	1.0%	106	5.5%	434	22.6%	393	20.5%	969	50.4
TOTAL	82692	100.0%	13782	5769	41.9%	33	0.2%	310	2.2%	2319	16.8%	3107	22.5%	8013	58.1

SPECIALTIES	TOTAL NUMBER OF CLAIMS '76-'84		# CLAIMS FOR DOCTORS WITH 10-17 CLAIMS number	percent	# CLAIMS FOR DOCTORS WITH 5 TO 9 CLAIMS number	percent	# CLAIMS FOR DOCTORS WITH 2 TO 4 CLAIMS number	percent	# CLAIMS FOR DOCTORS WITH ONE CLAIM number	percent
g.p./medical specialties	3999	35.7%	67	1.7%	361	9.0%	2089	52.2%	1482	37.1%
minor surgery	1091	9.7%	10	0.9%	137	12.6%	607	55.6%	337	30.9%
surgery	2711	24.2%	121	4.5%	442	16.3%	1493	55.1%	655	24.2%
ob-gynecology	1663	14.9%	94	5.7%	413	24.8%	888	53.4%	268	16.1%
high-risk specialties	1356	12.1%	94	6.9%	448	33.0%	628	46.3%	186	13.7%
anesthesia	372	3.3%	0	0.0%	16	4.3%	177	47.6%	179	48.1%
TOTAL	11192	100.0%	386	3.4%	1817	16.2%	5882	52.6%	3107	27.8%
TYPE OF DOCTOR										
M.D.	8777	78.4%	173	2.0%	1183	13.5%	4707	53.6%	2714	30.9%
D.O.	2415	21.6%	213	8.8%	634	26.3%	1175	48.7%	393	16.3%
TOTAL	11192	100.0%	386	3.4%	1817	16.2%	5882	52.6%	3107	27.8%

1668 unsettled PICOM claims and about 900 claims against corporations are not included because they could not be attributed to specific doctors.

* It is estimated that the average doctor was insured for 6 years between 1976 and 1984. This estimate is based on licensee data for M.D.s which includes interns and residents and therefore probably underestimates the length of time doctors are insured.
**Doctors who changed insurance companies between 1976 and 1984 could be counted more than once, because their claims with each company would be counted separately. This would inflate the total number of doctors with at least one claim against against them, but would underestimate the number of doctors with multiple claims.

*** [illegible] columns are percent of all doctors insured in that specialty from 1976-84

TABLE 2

OHMA 12-12-85

NUMBER OF DOCTORS WITH ONE OR MORE CLAIMS BETWEEN 1976 AND 1984 AND THE NUMBER OF CLAIMS AGAINST THEM BY SPECIALTY AND TYPE OF DOCTOR FOR THE THREE MAJOR INSURANCE COMPANIES

SPECIALTIES	NUMBER OF POLICIES WRITTEN: '76-'84 number	percent	NUMBER OF DOCTORS* policies/6	CUMULATIVE NUMBERS AND PERCENTS: DOCTORS WITH 10-17 CLAIMS** number	percent	DOCTORS WITH 5 TO 17 CLAIMS number	percent	DOCTORS WITH 2 TO 17 CLAIMS number	percent	DOCTORS WITH 1 OR MORE CLAIMS number	percent	DOCTORS WITH NO CLAIMS number	percent
g.p./medical specialties	52056	63.0%	8676	5	0.1%	68	0.8%	923	10.6%	2405	27.7%	6271	72.3%
minor surgery	7494	9.1%	1249	1	0.1%	24	1.9%	271	21.7%	608	48.7%	641	51.3%
surgery	9620	11.6%	1603	11	0.7%	86	5.4%	669	41.7%	1324	82.6%	279	17.4%
ob-gynecology	5368	6.5%	895	8	0.9%	79	8.8%	405	45.3%	673	75.2%	222	24.8%
high-risk specialties	4469	5.4%	745	8	1.1%	83	11.1%	314	42.2%	500	67.1%	245	32.9%
anesthesia	3685	4.5%	614	0	0.0%	3	0.5%	80	13.0%	259	42.2%	355	57.8%
TOTAL	82692	100.0%	13782	33	0.2%	343	2.5%	2662	19.3%	5769	41.9%	8013	58.1%
TYPE OF DOCTOR													
M.D.	71166	86.1%	11861	14	0.1%	218	1.8%	2103	17.7%	4817	83.5%	7044	59.4%
D.O.	11526	13.9%	1921	19	1.0%	125	6.5%	559	29.1%	952	16.5%	969	50.4%
TOTAL	82692	100.0%	13782	33	0.2%	343	2.5%	2662	19.3%	5769	41.9%	8013	58.1%

SPECIALTIES	# CLAIMS FOR DOCTORS WITH 10-17 CLAIMS number	percent	# CLAIMS FOR DOCTORS WITH 5 TO 17 CLAIMS number	percent	# CLAIMS FOR DOCTORS WITH 2 TO 17 CLAIMS number	percent	# CLAIMS FOR DOCTORS WITH ONE CLAIM number	percent	TOTAL NUMBER OF CLAIMS '76-'84 number	percent
g.p./medical specialties	67	1.7%	428	10.7%	2517	62.9%	1482	37.1%	3999	35.7%
minor surgery	10	0.9%	147	13.5%	754	69.1%	337	30.9%	1091	9.7%
surgery	121	4.5%	563	20.8%	2056	75.8%	655	24.2%	2711	24.2%
ob-gynecology	94	5.7%	507	30.5%	1395	83.9%	268	16.1%	1663	14.9%
high-risk specialties	94	6.9%	542	40.0%	1170	86.3%	186	13.7%	1356	12.1%
anesthesia	0	0.0%	16	4.3%	193	51.9%	179	48.1%	372	3.3%
TOTAL	386	3.4%	2203	19.7%	8085	72.2%	3107	27.8%	11192	100.0%
TYPE OF DOCTOR										
M.D.	173	2.0%	1356	15.4%	6063	69.1%	2714	30.9%	8777	78.4%
D.O.	213	8.8%	847	35.1%	2022	83.7%	393	16.3%	2415	21.6%
TOTAL	386	3.4%	2203	19.7%	8085	72.2%	3107	27.8%	11192	100.0%

1668 unsetteld PICOM claims and about 900 claims against corporations are not included because they could not be attributed to specific doctors.

* It is estimated that the average doctor was insured for 6 years between 1976 and 1984. This estimate is based on licensee data for M.D.s which includes interns and residents and therefore probably underestimates the length of time doctors are insured.

** Doctors who changed insurance companies between [illegible]6 and 1984 could be counted more than once, because their claims with each company would be counted separately. This would inflate the total number of doctors with at least one claim a[illegible]

TABLE 3

FREQUENCY OF CLAIMS
PICOM

Year	Exposure Units*	Projected Ultimate Claim Count	Claims Frequency
1975	3740	384	10.3%
1976	4485	402	9.0%
1977	3855	470	12.2%
1978	3588	498	13.9%
1979	3400	536	15.8%
1980	3200	463	14.5%
1981	3337	586	17.6%
1982	4298	817	19.0%
1983	6351	904	14.2%
1984	5969	945	15.8%

* Exposure Units are the number of insureds adjusted on an "equated-risk" basis.

Source: Milliman and Robertson, Physicians Insurance Company of Michigan Actuarial Rate Level Indications for 12/1/85, October 4, 1985

TABLE 4

AVERAGE INDEMNITY PER CLAIM OF ACTIVE MALPRACTICE INSURERS, 1976-1985

Current and 1976 Dollars

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	Average Annual Rate of Change 1981-85	1976-84	1976-85
Current Dollars													
MPMLC						$21,566	$34,458	$39,321	$50,105	$54,335	26.0%		
PICOM	$35,000	$4,317	$26,417	$20,594	$30,214	$27,160	$45,861	$52,152	$49,746	$38,370	9.0%	4.5%	1.0%
MedPro	$12,270	$20,882	$16,889	$27,526	$29,141	$29,700	$39,822	$36,057	$44,917			17.6%	
MHAMIC						$12,497	$30,160	$18,294	$30,361	$26,638	20.8%		
1976 Dollars													
MPMLC						$13,151	$20,197	$22,410	$27,588	$28,905	21.8%		
PICOM	$35,000	$4,043	$22,998	$15,905	$20,140	$16,563	$26,880	$29,722	$27,390	$20,412	5.4%	-3.0%	-5.8%
MedPro	$12,270	$19,556	$14,703	$21,258	$19,425	$18,112	$23,341	$20,549	$24,731			9.2%	
MHAMIC						$7,621	$17,678	$10,426	$16,717	$14,171	16.8%		

Note: Blank spaces indicate years in which an insufficient number of cases were closed to generate a reliable average figure, or for which data is not available.

Sources: Insurer responses to questionnaire of the House Insurance Subcommittee on Medical Malpractice, and subsequent private communications.

TABLE 5

AVERAGE EXPENSE PER CLAIM OF ACTIVE MALPRACTICE INSURERS, 1976-1985

Current and 1976 Dollars

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	Average Annual Rate of Change 1981-85	1976-84	1976-85
Current Dollars													
MPMLC						$2,265	$3,494	$4,596	$4,565	$6,230	28.8%		
PICOM	$1,822	$1,181	$1,092	$3,714	$3,690	$3,839	$5,099	$6,160	$6,397	$6,595	14.5%	17.0%	15.4%
MedPro	$3,096	$3,709	$4,657	$4,819	$5,941	$6,880	$7,190	$8,032	$7,892			12.4%	
MHAMIC						$3,074	$4,245	$5,479	$6,378	$5,638	16.4%		
1976 Dollars													
MPMLC						$1,381	$2,048	$2,619	$2,514	$3,314	24.5%		
PICOM	$1,822	$1,106	$951	$2,868	$2,460	$2,341	$2,989	$3,511	$3,522	$3,508	10.6%	8.6%	7.6%
MedPro	$3,096	$3,473	$4,054	$3,722	$3,960	$4,196	$4,214	$4,578	$4,345			4.3%	
MHAMIC						$1,875	$2,488	$3,123	$3,512	$2,999	12.5%		

Note: Blank spaces indicate years in which an insufficient number of cases were closed to generate a reliable average figure, or for which data is not available.

Sources: Insurer responses to questionnaire of the House Insurance Subcommittee on Medical Malpractice, and subsequent private communications.

TABLE 6

PHYSICIAN PREMIUMS OF ACTIVE MALPRACTICE INSURERS IN MICHIGAN, 1976 - 1986

$200,000/$600,000 Coverage
Current* and 1976 Dollars

GENERAL PRACTICE/FAMILY PRACTICE --NO SURGERY (M.D.)

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	*Total Percent Change 1976-86*	*Annual Percent Change 1976-86*
AREA I													
Current Dollars													
MPMLC	$2,250	$2,250	$3,448	$3,275	$3,275	$3,201	$3,201	$3,425	$4,076	$5,706	$6,163	174%	10.6%
PICOM	$2,300	$3,864	$4,512	$4,112	$3,072	$2,512	$2,512	$3,005	$3,360	$4,690	$5,660	146%	9.4%
MedPro	$1,320	$1,320	$1,320	$1,320	$1,435	$1,687	$1,687	$2,193	$3,218	$5,212	$7,498	468%	19.0%
1976 Dollars													
MPMLC	$2,250	$2,107	$3,002	$2,529	$2,183	$1,952	$1,876	$1,952	$2,244	$3,036	$3,168	41%	3.5%
PICOM	$2,300	$3,619	$3,928	$3,176	$2,048	$1,532	$1,472	$1,713	$1,850	$2,495	$2,909	26%	2.4%
MedPro	$1,320	$1,236	$1,149	$1,019	$957	$1,029	$989	$1,250	$1,772	$2,773	$3,854	192%	11.3%
AREA II													
Current Dollars													
MPMLC	$1,625	$1,625	$2,414	$2,293	$2,293	$1,921	$1,921	$2,260	$2,690	$3,766	$4,068	150%	9.6%
PICOM	$2,300	$2,900	$3,160	$2,672	$1,997	$1,633	$1,633	$1,954	$2,184	$3,049	$3,679	60%	4.8%
MedPro	$832	$832	$832	$832	$957	$1,126	$1,126	$1,464	$2,148	$3,361	$4,702	465%	18.9%
1976 Dollars													
MPMLC	$1,625	$1,522	$2,102	$1,771	$1,528	$1,171	$1,126	$1,288	$1,481	$2,003	$2,091	29%	2.6%
PICOM	$2,300	$2,716	$2,751	$2,064	$1,331	$996	$957	$1,114	$1,203	$1,622	$1,891	-18%	-1.9%
MedPro	$832	$779	$724	$643	$638	$687	$660	$834	$1,183	$1,788	$2,417	190%	11.3%

*As of mid-year for each year.
**Deflated by the Detroit CPI (1976 = 100)

TABLE 7

PHYSICIAN PREMIUMS OF ACTIVE MALPRACTICE INSURERS IN MICHIGAN, 1976 - 1986

$200,000/$600,000 Coverage
Current* and 1976 Dollars

GENERAL SURGERY (M.D.)

AREA I	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	*Total Percent Change 1976-86*	*Annual Percent Change 1976-86*
Current Dollars													
MPMLC	$12,312	$12,312	$12,718	$12,081	$12,081	$11,156	$11,826	$11,826	$14,074	$19,704	$21,280	73%	5.6%
PICOM	$11,500	$14,780	$15,804	$14,164	$10,880	$10,174	$10,174	$12,172	$14,398	$20,101	$24,255	111%	7.7%
MedPro	$5,905	$5,905	$5,909	$5,905	$9,619	$11,918	$11,918	$15,493	$19,628	$32,250	$46,539	688%	22.9%
1976 Dollars													
MPMLC	$12,312	$11,530	$11,072	$9,330	$8,053	$6,803	$6,932	$6,740	$7,749	$10,482	$10,938	-11%	-1.2%
PICOM	$11,500	$13,841	$13,759	$10,939	$7,252	$6,204	$5,963	$6,937	$7,928	$10,693	$12,467	8%	0.8%
MedPro	$5,905	$5,530	$5,144	$4,560	$6,412	$7,268	$6,985	$8,830	$10,807	$17,157	$23,921	305%	15.0%
AREA II													
Current Dollars													
MPMLC	$10,625	$10,625	$8,903	$8,458	$8,458	$6,694	$7,095	$7,805	$9,288	$13,003	$14,043	32%	2.8%
PICOM	$11,500	$11,092	$11,064	$9,208	$7,072	$6,613	$6,613	$7,912	$9,359	$13,066	$15,766	37%	3.2%
MedPro	$3,861	$3,861	$3,861	$3,861	$5,935	$7,353	$7,353	$9,559	$13,103	$20,798	$29,187	656%	22.4%
1976 Dollars													
MPMLC	$10,625	$9,950	$7,751	$6,532	$5,638	$4,082	$4,159	$4,448	$5,114	$6,917	$7,218	-32%	-3.8%
PICOM	$11,500	$10,388	$9,632	$7,111	$4,714	$4,033	$3,876	$4,509	$5,153	$6,951	$8,104	-30%	-3.4%
MedPro	$3,861	$3,616	$3,361	$2,982	$3,956	$4,484	$4,310	$5,448	$7,215	$11,064	$15,002	289%	14.5%

*As of mid-year for each year.
**Deflated by the Detroit CPI (1976 = 100)

TABLE 8

PHYSICIAN PREMIUMS OF ACTIVE MALPRACTICE INSURERS IN MICHIGAN, 1976 - 1986

$200,000/$600,000 Coverage
Current* and 1976 Dollars

OBSTETRICIANS (M.D.)

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	*Total Percent Change 1976-86*	*Annual Percent Change 1976-86*
AREA I													
Current Dollars													
MPMLC	$14,500	$14,500	$13,545	$12,868	$12,868	$11,866	$12,578	$13,458	$16,015	$30,198	$32,613	125%	8.4%
PICOM	$13,800	$14,780	$15,804	$14,164	$10,880	$11,663	$11,663	$13,954	$16,798	$23,452	$28,298	105%	7.4%
MedPro	$8,846	$8,846	$8,846	$8,846	$10,197	$12,634	$12,634	$16,424	$24,133	$48,375	$69,809	689%	22.9%
1976 Dollars													
MPMLC	$14,500	$13,579	$11,792	$9,938	$8,578	$7,236	$7,372	$7,670	$8,818	$16,065	$16,763	16%	1.5%
PICOM	$13,800	$13,841	$13,759	$10,939	$7,252	$7,112	$6,836	$7,953	$9,249	$12,476	$14,545	5%	0.5%
MedPro	$8,846	$8,284	$7,701	$6,832	$6,797	$7,704	$7,405	$9,360	$13,288	$25,735	$35,881	306%	15.0%
AREA II													
Current Dollars													
MPMLC	$12,250	$12,250	$9,481	$9,008	$9,008	$7,120	$7,548	$8,883	$10,570	$19,931	$21,526	76%	5.8%
PICOM	$13,800	$11,092	$11,064	$9,208	$7,072	$7,581	$7,581	$9,070	$10,919	$15,244	$18,393	33%	2.9%
MedPro	$5,157	$5,157	$5,157	$5,157	$6,291	$7,795	$7,795	$10,134	$16,110	$31,197	$43,781	749%	23.8%
1976 Dollars													
MPMLC	$12,250	$11,472	$8,254	$6,957	$6,005	$4,342	$4,424	$5,063	$5,820	$10,603	$11,064	-10%	-1.0%
PICOM	$13,800	$10,388	$9,632	$7,111	$4,714	$4,623	$4,443	$5,169	$6,012	$8,110	$9,454	-31%	-3.7%
MedPro	$5,157	$4,829	$4,490	$3,983	$4,194	$4,754	$4,569	$5,776	$8,870	$16,596	$22,503	336%	15.9%

*As of mid-year for each year.
**Deflated by the Detroit CPI (1976 = 100)

TABLE 9

PHYSICIAN PREMIUMS OF ACTIVE MALPRACTICE INSURERS IN MICHIGAN, 1976 - 1986

$200,000/$600,000 Coverage
Current* and 1976 Dollars

ORTHOPEDIC SURG. (M.D.)

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	*Total Percent Change 1976-86*	*Annual Percent Change 1976-86*
AREA I													
Current Dollars													
MPMLC	$14,812	$14,812	$20,000	$19,000	$19,000	$20,530	$21,146	$21,146	$25,244	$35,341	$38,169	158%	9.9%
PICOM	$13,800	$16,100	$17,544	$18,152	$15,211	$14,803	$14,803	$17,711	$19,797	$27,639	$33,351	142%	9.2%
MedPro	$8,846	$8,846	$8,846	$8,846	$11,216	$13,896	$13,896	$18,065	$27,351	$30,339	$45,688	416%	17.8%
1976 Dollars													
MPMLC	$14,812	$13,871	$17,412	$14,674	$12,665	$12,520	$12,394	$12,051	$13,899	$18,801	$19,619	32%	2.9%
PICOM	$13,800	$15,077	$15,273	$14,019	$10,139	$9,027	$8,676	$10,094	$10,900	$14,704	$17,142	24%	2.2%
MedPro	$8,846	$8,284	$7,701	$6,832	$7,476	$8,474	$8,145	$10,296	$15,060	$16,140	$23,483	165%	10.3%
AREA II													
Current Dollars													
MPMLC	$13,625	$13,625	$14,000	$13,300	$13,300	$12,319	$12,689	$13,956	$16,608	$23,250	$25,110	84%	6.3%
PICOM	$13,800	$12,076	$12,280	$11,800	$9,887	$9,622	$9,622	$11,512	$12,868	$17,966	$21,678	57%	4.6%
MedPro	$5,157	$5,157	$5,157	$5,157	$6,921	$8,575	$8,575	$11,148	$18,258	$20,253	$29,464	471%	19.0%
1976 Dollars													
MPMLC	$13,625	$12,760	$12,188	$10,272	$8,866	$7,512	$7,437	$7,954	$9,144	$12,369	$12,906	-5%	-0.5%
PICOM	$13,800	$11,309	$10,691	$9,113	$6,591	$5,868	$5,640	$6,561	$7,085	$9,558	$11,142	-19%	-2.1%
MedPro	$5,157	$4,829	$4,490	$3,983	$4,613	$5,229	$5,026	$6,353	$10,053	$10,774	$15,144	194%	11.4%

*As of mid-year for each year.
**Deflated by the Detroit CPI (1976 = 100)

TABLE 10

PHYSICIAN PREMIUMS OF ACTIVE MALPRACTICE INSURERS IN MICHIGAN, 1976 - 1986

$200,000/$600,000 Coverage
Current* and 1976 Dollars

Anesthesiology (M.D.)

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	*Total Percent Change 1976-86*	*Annual Percent Change 1976-86*
AREA I													
Current Dollars													
MPMLC	$14,812	$14,812	$15,449	$12,081	$12,081	$11,156	$11,826	$10,136	$12,063	$16,888	$18,239	23%	2.1%
PICOM	$13,800	$12,120	$13,052	$11,716	$7,671	$8,128	$8,128	$10,304	$11,998	$16,751	$20,213	46%	3.9%
MedPro	$8,846	$8,846	$8,846	$8,846	$9,619	$11,918	$11,918	$15,493	$19,628	$32,250	$46,539	426%	18.1%
1976 Dollars													
MPMLC	$14,812	$13,871	$13,450	$9,330	$8,053	$6,803	$6,932	$5,777	$6,642	$8,984	$9,375	-37%	-4.5%
PICOM	$13,800	$11,350	$11,363	$9,048	$5,113	$4,957	$4,764	$5,872	$6,606	$8,911	$10,389	-25%	-2.8%
MedPro	$8,846	$8,284	$7,701	$6,832	$6,412	$7,268	$6,985	$8,830	$10,807	$17,157	$23,921	170%	10.5%
AREA II													
Current Dollars													
MPMLC	$13,625	$13,625	$9,481	$8,458	$8,458	$6,694	$7,095	$6,690	$7,961	$11,146	$12,038	-12%	-1.2%
PICOM	$13,800	$9,092	$9,136	$7,616	$4,986	$5,283	$5,283	$6,698	$7,799	$10,888	$13,138	-5%	-0.5%
MedPro	$5,157	$5,157	$5,157	$5,157	$5,935	$7,353	$7,353	$9,559	$13,103	$20,798	$29,187	466%	18.9%
1976 Dollars													
MPMLC	$13,625	$12,760	$8,254	$6,532	$5,638	$4,082	$4,159	$3,813	$4,383	$5,930	$6,187	-55%	-7.6%
PICOM	$13,800	$8,515	$7,954	$5,882	$3,324	$3,222	$3,097	$3,817	$4,294	$5,792	$6,753	-51%	-6.9%
MedPro	$5,157	$4,829	$4,490	$3,983	$3,956	$4,484	$4,310	$5,448	$7,215	$11,064	$15,002	191%	11.3%

*As of mid-year for each year.
**Deflated by the Detroit CPI (1976 = 100)

TABLE 11

HOSPITAL PREMIUMS PER BED, MHAMIC, 1976 - 1985

$100,000/$300,000 Coverage
Current* and 1976 Dollars

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	*Percent Change 1976-85*
Current Dollars											
MHAMIC	$1,039	$824	$824	$730	$730	$730	$851	$1,055	$1,288	$2,083	100%
1976 Dollars											
MHAMIC	$1,039	$772	$717	$564	$487	$445	$499	$601	$709	$1,108	7%

Source: MHAMIC Response to Questionnaire of the House Insurance Subcommittee on Medical Malpractice, Response to Question 13.

*As of mid-year for each year.
**Deflated by the Detroit CPI (1976 = 100)

michigan hospital association

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Spencer C. Johnson
President

December
Six
1 9 8 5

Sandra L. Miner, Chairperson
Statewide Health Coordinating Council
Department of Management and Budget
P.O. Box 30026
Lewis Cass Building
Lansing, MI 48909

Dear Ms. Miner:

I received the packet of materials for the executive committee meeting on December 11, which indicated that the medical malpractice reform legislation currently before the House of Representatives will be discussed. Unfortunately, I cannot attend the executive committee meeting. Since the hospitals of Michigan as well as our patients have much at stake in this malpractice debate, I am providing my thoughts on this issue in this letter.

During the last ten years the number of medical malpractice suits has more than tripled while the average size of jury awards has more than quadrupled. During the last two years liability insurers have seen one disaster after another drain their resources while interest rates and, therefore, their ability to make up these losses has declined. These events have created the crisis we are now focusing on. I call it a crisis, not because it has gotten outrageously expensive to purchase insurance coverage, but, because of what these costs are doing to the medical delivery system. Access to quality health care in Michigan is diminishing. Many physician specialists in the so-called "high risk" specialties have restricted their practice or have totally removed themselves from practicing the specialty for which they have been educated. These results are particularly noteworthy in our urban inner-city areas and in rural areas of our state.

Hospitals, whose mission is to provide needed care, are struggling to maintain access to all as a result. Currently, hospitals, through their insurance underwriters or their self insured funds, are paying approximately two-thirds of all the malpractice costs in the state. Almost 75 percent of this year's increase in hospital costs is directly attributable to the increase in malpractice costs to hospitals. This means that every patient in a Michigan hospital is paying about $164 just to support the hospitals' malpractice costs. If this trend continues, not only will the costs continue to rise, but access for our state's poor and people in rural Michigan will decline.

The Michigan Legislature is now focusing attention on this problem. They are looking at three broad areas for a solution. These are disciplinary actions towards medical providers, insurance reform, and tort reform. The physician community and the hospital community have supported a series of legislative reforms to strengthen, with both dollars and clout, the activities of the Michigan Department of Licensing and Regulation's disciplinary boards. However, evidence indicates that the vast majority of medical malpractice suits are not filed against "bad doctors." Indeed, the likelihood of being sued increases directly with the qualifications of the physician sued. That is, the more training and the more specialized a physician is, the more likely he or she will be sued and the larger, on average, will be the awards. The reason for this, which is often lost in a discussion of this issue, is that doctors refer to higher order specialists as the risk increases. It is precisely this referral system, which has made American medicine among the most advanced in the world, that brings about the current unfortunate situation for these doctors and the hospitals that they practice in. It is my conclusion that while reform and enhanced financing of the medical discipline system is needed, it won't do much to control current or future malpractice insurance costs.

Some have suggested that this is not a malpractice crisis at all. They claim this is an insurance crisis and, indeed, that we are suffering from a "scam" perpetuated by the insurance underwriters. While I don't know much about the international insurance market, I do know that in Michigan, two of the three major physician insurers are Michigan-based companies, owned by the doctors they insure. I also know that all but a small number of Michigan hospitals are either self insured (i.e., directly at risk for any losses) or are insured by their own mutual insurance company. The last remaining large out-of-state hospital malpractice insurer withdrew from the state of Michigan last July. It would seem to me that if we were observing an insurance scam, they would have jacked the rates rather than withdrawn, and I certainly see no reason for hospitals and doctors to pull a scam on themselves at a cost of tens of millions of dollars.

One "solution" that has been offered to assure that doctors and hospitals will be able to purchase insurance is to form a new company, either under the aegis of government or with the support of government. It should be clear, however, that if this new organization were to exist in Michigan now, the rates they would charge would have to be at least as high as the rates currently being charged by the Michigan companies. Therefore, I conclude that, by itself, this is no solution.

This brings us to the area of tort reform as a necessary ingredient to bring the current crisis back into manageable proportions. What we need, I believe, is some balance in the system. The current system encourages suits because there has been a "bad outcome" rather than because negligence has occurred. Awards are too often made on the basis of sympathy rather than fact. Our judicial system was not designed to handle many of the cases in the medical malpractice area they now see.

And, the person who is truly harmed due to negligence winds up receiving no more than one-third of all the dollars that flow through the medical malpractice system; legal fees, expert witness fees, and administrative costs siphon off dollars that should rightfully go to those harmed.

What is needed then are methods to bring the system under control so that it works for, rather than against, a truly harmed patient and doesn't bankrupt the medical delivery system. Several proposals currently before the House are, to my view, clearly supportable on these grounds. For example, one way of sharply reducing overall legal expenses (both plaintiff and defense) would be to require a review by an expert panel of the documentary evidence as a condition for filing suit. The expert panel would be made up of one expert selected by plaintiff's attorney, one expert selected by defense counsel, and one expert selected either by joint agreement of the parties or by the court. The panel would be charged with determining only whether negligence occurred. Their findings would be admissible in court and they would be callable as witnesses. This process has been tried in this form in several states -- with great success. In Indiana, well over 90 percent of all potential malpractice cases are resolved before trial. Plaintiffs under this mechanism get an opportunity to determine if there is sufficient reason to pursue the case (although they may, without cost, pursue the case in court regardless of the panel's findings.) Defendants get to determine very quickly whether an appropriate settlement offer should be made. The process is quick and inexpensive and should be tried in Michigan.

Current law in Michigan effectively allows a suit to be filed whenever a potential plaintiff wishes -- regardless of how long after the maloccurrence. Other states have put limits on how long after the occurrence a suit may be filed, usually two years or until an infant reaches age six or eight. The situation in Michigan now leaves malpractice insurers the unenviable task of guessing, today, how many lawsuits will be filed in the long term future, and how much money juries at that future date will award. Change is clearly needed here.

Under current Michigan law, plaintiff attorneys, in trying to do the best they can for their clients, often "sue the world" as a strategy. That is, regardless of who might be responsible for the maloccurrence, you sue anyone and everyone connected with the case in hopes that some degree of fault can be attributed to them so that your client might collect as much as possible. While this probably has the effect of increasing the size of the final award, it also assures that the total legal costs of the suit will be astronomical.

This concept, that defendants are jointly and severally liable for a maloccurrence, is clearly unfair to the defendants because a minor party to the suit can, and often does, wind up paying the entire award. This means that a physician with appropriate coverage, but with minimal responsibility for the event, will pay a far larger portion of the award than another physician who is more at fault but carries less adequate insurance. This same situation applies to the hospitals and is probably the most significant reason why hospitals in Michigan pay two-thirds of the total malpractice bill in this state.

An alternative approach, and one utilized in other states, attributes the financial responsibility in direct proportion to the medical responsibility for the maloccurrence. This has the direct effect of making the negligent party financially responsible for their action.

While I've only discussed three areas of tort reform, I believe that this letter will give you a flavor for the issues being debated. I hope you have a good meeting. I look forward to seeing you at the January SHCC meeting.

Sincerely,

Steven B. Scheer
Deputy Director

SBS:jr

cc: SHCC Executive Committee Members

THE MYTH of a "MALPRACTICE CRISIS"

Health care costs continue to skyrocket across the state and nation. Insurance companies, medical facilities and doctors have placed part of the blame on lawsuits charging medical malpractice as well as on the verdicts awarded to victims. Physicians, hospitals and insurance companies have been urging changes in our legal system in order to control malpractice litigation.

> ***"We are all potential victims"***
>
> Medical malpractice occurs when a patient is injured by a doctor or health-care provider who administers careless, negligent or improper care. If there were no serious errors, there would be no medical malpractice.

Aside from promoting and protecting the self-interests of the health care industry, these changes will have a profound effect on those who are injured because of medical error or negligence. The laws which are being reviewed tend to be approached from the perspective of insurance companies, doctors, lawyers and other special interest groups. But how about the rest of us? All who use the health care system have a vital interest in the outcome. It is necessary to protect not only the victims of medical malpractice, but **all** future victims.

The following summarizes the changes now before the State Legislature. It is important to understand these issues . . . after all, we are all potential victims.

How much is a malpractice injury worth?

A baby who is injured at birth by a careless doctor, a man who is paralyzed by an overdose of the wrong medication, small children who lose their mother due to medical negligence, what is their pain and suffering worth?

Not more than $250,000 according to the proposals put forth by doctors and insurance companies. All would be limited to that amount for their pain and suffering if the proposed cap for non-economic damages is approved by the legislature. The proposed law would prejudge victims by a panel of doctors, instead of by a jury of impartial citizens. Under the present system, a victim of severe, undisputed medical negligence is entitled to the amount of money a court and jury find appropriate to compensate for the injury. No matter what the injury, no matter how much the victim will suffer, no matter how old the victim is and how long he or she is expected to live in pain and impairment, $250,000 is the most that can be recovered. How much is an arm or leg worth to you? How much is your child's life worth? The doctors and insurance companies have decided $250,000 and no more.

Who is responsible for a malpractice injury?

Many malpractice episodes result from error or negligence of more than one person. "Joint and several" liability allows the victim of more than one guilty person to sue **all** responsible parties for the injury.

A person damaged because a hospital, a nurse, a lab technician and physician all mishandled the case may now sue all three.

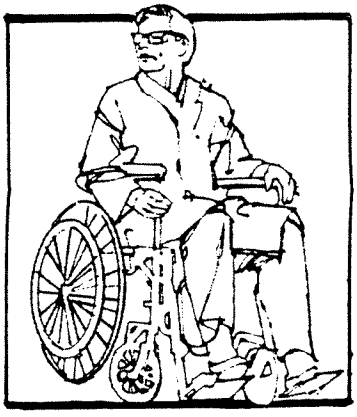
If this law is changed, the victim would be forced to prove the proportion of blame to be assigned the nurse, lab technician and doctor and try to collect the appropriate amount from each. If the nurse or technician are uncollectable, uninsured or underinsured, it is the victim's bad luck; the hospital/doctor's insurance will no longer be applied toward the debt of the other negligent parties. The victim will not be compensated for the proved damages.

Who should judge whether malpractice is committed?

Under the present system, malpractice claims are presented to a court and jury of citizens who hear testimony from both sides, including expert witnesses and others.

Insurance companies and the medical establishment propose to change the system by requiring all victims of malpractice to appear before a pre-trial screening panel consisting of three doctors and a non-voting attorney as a condition to filing a lawsuit. These doctors would offer an opinion on the case which has been filed against a fellow doctor or health care facility, or employee. Their findings would be entered into evidence at trial. In addition, either the victim or the defendant doctor could demand that one of the three panel members testify at trial. The medical profession would, in effect, be acting as their own judge and jury.

Delaying Payment to Victims



Insurance companies would like to pay malpractice settlements in periodic long-term payments as opposed to a lump sum award. Thus, the insurance companies could retain the funds which represent the settlement in their long-term investment portfolios and continue to earn interest and profit from the money assigned to the victim.

If the victim dies before the settlement is disbursed, the insurance companies may keep the remaining monies, unless the projected earnings were assigned by the Court to the victim's dependents. In the case of self-insured hospitals, the long-term payment would, in effect, be the same as a lottery for their malpractice patients.

If a patient is mistreated and awarded a lump sum by a jury, the hospital may invest the settlement and pay the victim over a period of years out of the interest earned from investing the money.

Should the Victim pay twice?

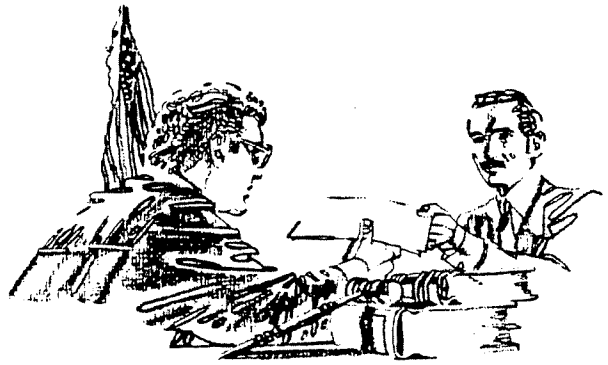
Michigan law does not allow the persons responsible for malpractice to benefit from any insurance or other benefits belonging to the injured victim. This is called the "Collateral Source Rule."

Insurance companies and doctors want to eliminate this protection. If they succeed, the victim's own medical insurance, for example, which covers the malpractice injury, and for which he has already paid, will be deducted from any award or settlement. Without the "Collateral Source Rule", those who committed the malpractice would benefit from the victim's plight.

The abolition of the collateral source rule has already been considered in four states; three found such action to be unconstitutional (North Dakota, New Hampshire and Ohio) because it discriminates in **favor** of health care providers. To reduce damage awards by the amount of any nonrefundable collateral benefits received by the victim clearly confers an economic benefit upon the negligent physician or medical facility and reduces conduct by physicians and hospitals.

Few Sue. . . even fewer win

Many people seem to feel that attorneys file 'frivolous' lawsuits because they have nothing to lose by doing so. This is not true.



Medical malpractice suits are taken by attorneys on a contingency fee basis. If the suit fails, the attorney gets nothing. The considerable out-of-pocket expenses incurred by attorneys filing these suits, including the cost of depositions, expert witnesses, document copying, not to mention the attorney's time and effort, are prohibitive. Attorneys cannot afford to waste time and money on non-meritorious suits.

Even more important, a Michigan Court Rule (2.114 [D and E]) states that if an attorney signs his or her name to a pleading that is not grounded in fact or good faith argument, he or she may be forced by the Court to pay the other side's attorney fees and the reasonable expenses incurred.

How long before you know you are a victim?

At present, a child who has been injured by a careless medical professional has until the age of 18 to sue for damages.

The proposed law offered by doctors and insurance companies would **reduce this by 12 years.** In order to file a malpractice lawsuit, symptoms would have to be detected, damages apparent, and a lawyer retained by the time the child is **eight years old.**

The problems with this statute of limitations are obvious. If the symptoms don't appear until the victim is an adult, there can be no lawsuit and no damages. What if a child's parents don't realize they have a claim until the child is nine years old? Or what if the parents are unaware of their rights, or simply neglect to seek legal assistance? This statute would certainly deprive many malpractice victims of their chance to recover damages. These examples indicate the far-reaching effects of how changes in our present system will affect you, the consumer.

All of us are concerned about rising health care costs. Restricting the rights of citizens who are injured by the health care providers — doctors, technicians, hospitals and others — will deprive all of us of the right to protection against error and negligence. The costs to the patient of malpractice — a wrong diagnosis, improper drugs, a forgotten sponge — could be enormous. They should be compensated fairly for their injury.

The only fair method so far devised to compensate for wrongful medical treatment is a money award. If our right to sue is diminished or restricted, the victim will be forced to pay — and few of us can afford the exhorbitant costs of medical care to correct or repair the damage, to say nothing of the pain and suffering.

Without malpractice, there would be no malpractice lawsuits, no insurance premiums and no need to change the law. If there are to be changes, the most effective efforts should be toward the reduction or elimination of bad and dangerous medical practices.

"Without the fear of mistreatment or medical neglect"

In all the discussion about malpractice — while insurance companies decry poverty and doctors say they are being squeezed out of their practices and the lawyers say there is no crisis — in all the hubbub, no one has sought out the opinions and the experience of the people. Medical care is a basic need and human right. Each of us is entitled to the best possible medical attention our society can afford, and it should be accessible without the fear of mistreatment or medical neglect.

It is not easy to judge the price, for example, of an unnecessary overdose of a prescription drug or the loss of a leg due to surgical error or brain damage at birth due to a misdiagnosis. How much are these worth? We don't know.

We are all medical patients. Therefore we are all potential victims. And we have a stake in this important discussion.

The Rt. Rev. Coleman H. McGehee
Episcopal Bishop of Michigan

"You must understand that some of the malpractice out there is so grevious, offensive, implausible as to beggar the imagination. Without real malpractice, we would not have this problem."

Barry S. Shiffrin, M.D.
Director of Maternal/Fetal Medicine
Huntington Memorial Hospital
Pasadena, CA – June 21, 1985

A Special Message for Senior Citizens

Restrictions and limits on the right to sue for malpractice would seriously affect senior citizens. As our population grows older, medical needs become greater. Unfortunately, the dangers of medical error and neglect are also increasing.

All citizens, especially seniors, are entitled to quality medical care. If they are victimized through careiessness or neglect, they deserve the right to seek fair and adequate compensation.

Sidney Rosen
Director, Senior Citizens Department,
City of Detroit

Each hour 50 more patients become victims

Medical malpractice does not discriminate based on age, sex, race or economic standing. It will maim or kill anyone who is unlucky enough to be touched by one of the nation's estimated 66,000 incompetent doctors.

Between 136,000 and 310,000 patients are injured or killed each year due to doctors' errors. There are no exact figures because organized medicine is unwilling or unable to keep better records. Another 300,000 patients die each year from the dangerous infections they contracted while staying in a hospital

Michigan is home to between 600 and 1,000 of these unsafe doctors. Of the 20,000 doctors practicing in Michigan today, 1,400 are thought to have alcohol problems. In the last seven years, only 31 Michigan doctors have come to the attention of the Michigan Board of Medicine with alcohol and drug problems.

For example:

A Michigan psychiatrist, currently practicing, seduced his severely disturbed psychiatric patients into homosexual relationships.

Another Michigan doctor was kicked off two hospital staffs, sued 10 times for malpractice and charged with Medicare fraud. He is still practicing.

A Michigan gynecologist performed an abortion on a woman seven months pregnant. He is still treating women today.

From 1977 to 1982, 6,000 Michigan residents filed malpractice lawsuits, Another 60,000 people injured by medical malpractice suffered in silence. If these laws pass, you may not have the right to receive adequate compensation. **That** would be a **medical malpractice crisis.**

Consumers and Medical Malpractice

We've heard a lot recently about medical malpractice and the increasing costs of insurance for practicing physicians.

The doctors say it's a crisis. The lawyers, who handle malpractice suits, say it's an "uncrisis", an unfair scare campaign to raise insurance rates.

And now legislation is being considered to change state law on such matters as limiting the amounts of the awards to victims of malpractice, establishing restrictions on the right to sue and establishing committees of doctors to rule on the charges of malpractice instead of taking the cases to a court and a jury.

In the debate about malpractice legislation, what seems to be overlooked is the patient. Shouldn't we be more concerned about reducing or eliminating those medical practices that bring unnecessary injury and suffering to the victims of malpractice?

Medical malpractice **is** a fact of life. . . and death. And we have devised no other way to compensate for a lost limb, a wrongful and tragic mis-diagnosis, or a gross overdose of medication or radiation than money awards.

Those awards are intended to compensate for an injury as well as to provide needed and expensive care for the victim, often for the rest of his or her life.

Whatever the outcome of the current debate over the malpractice "crisis", and whatever our lawmakers do in Lansing, our first concern is the quality of health care.

As one doctor has put it, "Malpractice is a medical problem, not a legal one, and those injured as a result of negligence are entitled to fair and prompt compensation." After all, we are all potential victims.

Esther Shapiro
Detroit Consumer
Affairs Department

CALL or WRITE: To protect your rights as a health care consumer, call or write to your State Representative, Senator and Governor Blanchard to oppose laws which limit your ability to sue in the event of medical malpractice.

M.A.I.M. / **Michigan Citizens Against Incompetent Medicine**

P.O. Box 550 • Linden, Michigan 48451 • (313) 735-9304

PublicCitizen
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Public Citizen Health Research Group Report

MEDICAL MALPRACTICE: THE NEED FOR DISCIPLINARY REFORM, NOT TORT REFORM

Sidney M Wolfe, M.D., Henry Bergman, George Silver, M.D.

During the past year, there has been an unprecedented amount of attention given to the most prominent symptom of the problem of inadequate quality control and discipline of American doctors. The "symptom" is the malpractice insurance crisis, wherein some doctors in certain subspecialties in some parts of the country are no longer willing or able to afford the skyrocketing malpractice premiums being requested by the malpractice insurance companies. The "treatment" for this problem of incompetent doctors -- largely prescribed by the AMA and its state affiliates -- has been to focus on the symptoms rather than getting at the underlying disease. Just as it did during the last malpractice crisis ten years ago, organized medicine has succeeded in diverting attention away from the issue of the dangerously inadequate discipline of doctors by going all out to pass state tort reform laws that will, in a variety of ways discipline injured patients or the families of dead patients and their lawyers instead of the doctors.

In this report, we review the following:

I. State-by-state comparisons in disciplining doctors:

- Of almost 400,000 patient care doctors in the U.S., only 563 had their licenses revoked or suspended or were put on probation in 1983.

- Utah, with 5.2 such actions per 1,000 doctors was 36 times higher in discipline than Massachusetts which had only .14 of these serious disciplinary actions per 1,000 doctors.

- 10 states, with a total of over 18,000 physicians had no serious disciplinary actions in 1983. For some of these 10 states, it is possible that they actually disciplined doctors but did not report their actions to the Federation of State Medical Boards from which we obtained the data.

- New York, the state with the biggest increase in malpractice premiums this year, has one of the lowest rates of doctor discipline - only .49 serious actions per 1,000 physicians or 21 such actions per 42,063 physicians. This was less than 1/10th of the rate of disciplinary actions in Utah.

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II. How Much Malpractice is Actually Ocurring?

The gap between negligent actions by doctors and discipline of doctors. Although there were only 563 serious disciplinary actions in 1983 of the 389,467 non-Federal patient care doctors, the actual number of instances in which a patient was injured as a result of negligence (the definition of malpractice) was at least 250 times higher. Estimates range from 136,000 to 310,000 times a year in which patients are injured or killed due to errors by doctors.

III. How to Decrease the Amount of Malpractice and Therefore the Number of Malpractice Suits.

The striking variation between states in serious disciplinary action is not likely due to inherent differences between the quality of medical practice in one state vs. another. Rather, the main explanation is that some states are much more active than others in disciplining physicians. Among the remedies we propose are:

- Urging that all doctors pay at least $500 per year for their medical license, thus raising about $200 million dollars in state revenues to be used for disciplining doctors. For 1983, state fees for license renewal ranged from $15 to $150. Most states were under $100.

- Passing strong legislation in states to greatly expand the size and strength of the licensing (doctor discipline) function. This would include subpoena power, larger staff, public hearings and non-physician members of boards: states such as California, Florida, Kentucky and others which have done this have better records than most other states do.

- Experience-rating of doctors by insurance companies so the good doctors stop subsidizing the relatively few with worse performance records. Better performance, lower premiums, worse performance higher premiums.

- Requiring attorneys to turn over to state licensing boards information about doctors after patients prevail in a settlement or adjudication of a malpractice suit.

- Requiring all other data, such as that collected by Professional Review Organizations, (PRO's) concerning doctors'performance in treating Medicare and Medicaid patients to be made part of doctors files in the state licensing bureaus.

- Requiring periodic recertification of doctors based on written exams and audit of doctor performance such as medical record review.

In summary, the best and only permanent remedy for the malpractice crisis is not tort reform but doctor discipline

I. State-by-State comparisons in Disciplining Doctors
As seen in the accompanying table, in 1983 there were 563 serious disciplinary actions (revocations or suspensions of license or probations) taken against U.S. physicians by state licensing boards as reported to the Federation of State Medical Boards (F.S.M.B.). This amounts to an average of only 1.45 serious disciplinary actions per 1,000 physicians for the whole country or 1 doctor out of 690. The range is from Utah - the state with the highest rate of 5.2 actions/1,000 --- doctors or 1 doctor out of 192 having their license revoked suspended or being put on probation - to 9 states plus D.C. which, in 1983, had reported no serious disciplinary actions to F.S.M.B. A total of twenty-two states, including most of the largest states - Ohio, Texas, New York, Pennsylvania, Illinois, Massachusetts - reported fewer than 1 serious disciplinary action per 1,000 physicians. Both New York & Massachusetts are facing huge increases in malpractice premiums.

It is of interest that in that mecca of medical excellence, Massachusetts, there were only 2 serious medical disciplinary actions in 1983 for 13,697 physicians for a rate of .14 per 1,000 physicians or one per 6,849 doctors. Despite Boston and environs, there is no reason to believe that the quality of medical practice in Massachusetts is acutally thirty-six times better than in Utah, thereby explaining why Utah's rate of serious discipline is thirty-six times higher than Massachusetts. Rather, Utah probably has, overall, doctors of the same quality as Massachusetts - and other states, but has a more effective system of doctor discipline.

In Florida, for example - now one of the better states as far as doctor discipline (3rd), there was a three-fold increase in total disciplinary actions following a reformation of the organization and operation of the state medical regulatory board for doctors (and other health professionals). Thus, increased numbers of disciplinary actions in states reflect better discipline as also seen in California which during the early 1970's in the wake of the last medical malpractice crisis, set up its Board of Medical Quality Assurance.

From 1982 to 1983, as seen in the table below, there was a 4% increase in serious disciplinary actions, with a 66% increase in probations but a 23% decrease in licenses revoked and 10% decrease in licenses suspended. Thus, among the serious disciplinary actions, the most serious, revocations and suspensions, have decreased.

	1982	1983	Change
Total Actions	541	563	+ 4.1%
Licenses Revoked	234	181	-22.6%
Licenses Suspended	168	151	-10.1%
Probation	139	231	+66.2%

60

II. How Much Malpractice is Actually Occurring?

Even if all states disciplined doctors at the rate Utah does, (5.2 per 1,000 doctors) this would mean a national total of only 2025 revocations, suspensions and probations instead of the actual national total of 563. That even this expanded figure is but a fraction of the number of times patients are injured or killed as a result of negligence - error - by doctors can be derived several different ways:

1. Medical Malpractice Commission Estimate: 203,000 instances of malpractice.
Based on studies it commissioned, the HEW Malpractice Commission found that a large number of injuries which occurred to hospitalized patients were the result of negligence. Eli Bernzweig, the Director of the Commission, estimated that 3.6% of patients who enter hospitals are injured and that 14.5% of these injuries were due to negligence (J. Legal Medicine, Feb., 1976). Applying these figures to 1983 U.S. hospital admissions, (38.8 million - HHS 1983 Summary: National Hospital Discharge Data) we get 3.6% x 38.8 million or 1.40 million hospital injuries with 14.5% of these or 203,000 people being injured as a result of negligence.

2. Surgical Admission Estimate: 136,000 injuries to patients secondary to doctor errors.
A 1981 study based on 5,612 surgical admissions to Boston's Peter Bent Brigham Hospital found that 36 patients suffered adverse outcomes "due to error during care" (New Eng. J. Med. 1981, 304, 634-7). If this rate of malpractice (injury due to negligence) is applied to all 1983 surgical admissions - there are an estimated 136,000 injuries to surgical patients caused by doctor error. This estimate is lower than the other because it does not include patients admitted to the hospital on non-surgical services.

3. Malpractice Claims Paid to Plaintiffs times 10 = 164,000 instances of malpractice.
Based on 1984 A.M.A. data for doctor-owned insurance company claims paid and extrapolating to all of the 389,467 patient care non-Federal doctors in the U.S., there were approximately 16,400 times in 1983 where patients were awarded damages in malpractice suits either by settlement or adjudication. According to A.M.A. executive Dr. James Todd, "95% of our indemnity dollars go to pay claims that by medical peer review are indefensible (Internal Medicine news Dec. 1-14, 1984). A 1976 California study, recently quoted in Medical World News (July 22, 1985) found that only 1 in 10 cases of adverse patient outcome due to malpractice, in which the patient would probably prevail are actually brought to litigation. Thus, for 16,400 actual plaintiff awards for medical malpractice, there are 10 times as many or about 164,000 which actually occur.

4. California Medical Insurance Feasibility Study Projection to all of U.S.: 310,000 Instances of Malpractice
Based on a study in California it was determined that of 3 million hospital admissions in one year, "24,000 patients had an adverse outcome that appeared to be the fault of one or more health care providers and for which the patient would likely be successful in litigation" (Medical World News, July 22, 1985) Applied to the 38.8 million patients hospitalized in the U.S. in 1983, this amounts to 310,400 instances in which patients were injured (or killed) as a result of negligent medical behavior.

It must be pointed out that all four of these estimates are probably low because none includes those instances of malpractice which occur to people outside of the hospital.

Even using the lowest of these estimates, 136,000 instances of malpractice a year, the number of times doctors are seriously disciplined - 536 in 1983, represents only one in two-hundred fifty two. In other words, out of every 252 times that a patient is injured or killed as a result of doctor negligence, only once is a serious disciplinary action taken against a doctor.

In summary, there is a tremendous and dangerous gap between the amount of malpractice - negligent doctor behavior resulting in injury or death - and the amount of doctor discipline.

III. How to Decrease the Amount of Malpractice and Therefore the Number of Malpractice Suits

1. Increase Doctor License Fees to at Leat $500 per year
Instead of doctors complaining about spending thousands, tens of thousands a year on malpractice insurance, they should push for annual medical licensure fees to be raised to at least $500 with all of the money going to identification and discipline of doctors who are incompetent or otherwise practicing bad medicine. This would create an annual fund of 200 million dollars for states to use, far more than is now being spent and would prevent malpractice.

2. Passing Stronger State Doctor Discipline Legislation
as has already occurred in Florida, Kentucky and other states, the real remedy to the malpractice crisis has to include greatly strengthening the size and powers of the state licensing and disciplinary function. With these changes, states such as California, Florida and Kentucky have greatly improved their discipline of doctors. Without such legislation as in New York, Massachusetts, and most of the states, the record of disciplining doctors is abysmal.

3. Insurance Companies should Experience-Rate Doctors within a Subspecialty.
Why should the many excellent physicians who have not had adverse malpractice adjudications or settlements against them have to subsidize the premiums of their less competent

colleagues who now pay the same as they?

4. All Attorney's Should be Required to Immediately Turn Over To Their Respective State Medical Licensing Board the Results of Settlements or Adjudications Which Result in The Payment of Claims to Injured Patients.
At present, the terms of settlement often prevent attorneys from supplying this important information to the file of the involved doctor.

5. All Data Which Relates to the Performance of a Doctor - Such as PRO (Professional Review Organization) Data Collected on Doctors' Performance Taking Care of Medicare and Medicaid Patients Should Also Be Made a Part of the Doctors File at the State Licensing Board.

6. Require periodic recertification of doctors based on written exams and an audit of doctors performance such as medical record review.

CONCLUSION

In response to doctors' pressures for malpractice premium cost relief, a number of states have already passed anti-consumer laws that met most of the doctors demands; many others are in the process of doing so. Limitations have been placed on the access of plaintiffs to the courts; ceilings have been placed on awards and large payments have been stretched out over many years; lawyers fees have been reduced; limitations have been placed on awards for pain and suffering.

It is time to demand quid-pro-quo to attack the basic source of the problem, malpractice and malpractitioners, to include legislative requirements for more intensive and active pursuit of incompetence among medical practitioners. It is time to realize that the competent and consciencious practitioners who are in the majority and who now suffer the obloquy of guilt by association are unjustly paying the price for an unfortunately too substantial minority of competent, careless, undertrained or disabled physicians. It is time for the medical profession to give more than lip service to the weeding out of bad apples.

All of this will cost money, and priorities must be set on how to spend limited resources. Our response to that is simple: If only 7% of the almost $3 billion now spent to settle medical malpractice claims were devoted to taking the corrective, preventive measures, there would be far less malpractice and no periodic cost crises - and most important, far less injury to patients. Our proposal for a $500 per year license fee would raise the 200 million to carry out these crucial measures.

SERIOUS MEDICAL DISCIPLINARY ACTIONS:

REVOCATIONS, SUSPENSIONS & PROBATIONS
in 1983 by State Medical Licensing Boards[1]

State	Rank	Actions per 1000 doctors	Total serious actions[2]	Revocations	Suspensions	Probations	Non-federal patient care doctors[3]
UTAH	1	5.20	12	6	0	6	2306
OHIO	2	4.25	32	4	9	19	7521
FLA	3	4.15	71	36	14	21	17105
ARK	4	3.27	9	4	5	0	2753
ARIZ	5	3.22	15	5	4	6	4665
MICH	6	3.00	41	7	21	13	13666
KY	7	2.83	38	9	20	9	13416
MO	8	2.70	20	5	2	13	7396
COLO	9	2.50	13	5	2	6	5209
NV	10	2.32	11	2	2	7	4736
CA	11	2.29	117	29	26	62	50981
VA	12-13	2.26	20	4	3	13	8816
WA	12-13	2.26	4	1	0	3	1766
NH	14	2.11	4	2	0	2	1899
ALAS	15	2.02	1	1	0	0	493
ME	16	1.84	3	3	0	0	1628
ORE	17	1.80	8	1	0	7	4443
WISCON	18	1.78	1	1	0	0	559
NEV	19	1.70	2	0	0	2	1174
LA	20	1.42	9	2	5	2	6322
NEB	21	1.37	3	1	1	1	2189
S.DAK	22	1.29	1	1	0	0	775
S.C.	23	1.27	5	0	5	0	3944
N.C.	24	1.21	10	7	1	2	8266
IND	25	1.20	8	0	3	5	6675
IOWA	26	1.15	4	1	0	3	3474
N.D.	27	1.14	1	0	1	0	870
MIS	28	1.11	8	6	2	0	7204
MINN	29	1.09	8	3	1	4	7276
CONN	30	0.85	6	2	1	3	6946
OHIO	31	0.65	11	6	5	0	16671
TEX	32	0.62	13	7	4	2	21024
OK	33	0.53	2	0	0	2	3786
NY	34	0.49	21	13	3	5	42063
PENN	35	0.48	10	3	3	4	20937
IL	36	0.45	9	2	4	3	19842
WASH	37	0.43	3	0	1	2	6926
TENN	38	0.42	3	1	1	1	6887
MISS	39	0.37	1	0	1	0	2672
MD	40	0.30	3	0	0	3	9866
MASS	41	0.14	2	1	1	0	13697
DEL	42-51	0	0	0	0	0	955
VER	42-51	0	0	0	0	0	996
MONT	42-51	0	0	0	0	0	1003
IDA	42-51	0	0	0	0	0	1024
N.H.	42-51	0	0	0	0	0	1455
R.I.	42-51	0	0	0	0	0	1797
W.VA.	42-51	0	0	0	0	0	2540
D.C.	42-51	0	0	0	0	0	2628
KANS	42-51	0	0	0	0	0	3472
ALA	42-51	0	0	0	0	0	4708
TOTALS (all states)		1.45	563	181	151	231	389467

1. With the exception of California, all data is from the Federation of State Medical Boards (FSMB). Since they did not supply California data to us, we obtained such data from the California Boards of Medical Quality Assurance and Osteopathic Examiners. Data for Florida, Michigan, Arizona, New Mexico, California, Washington, Pennsylvania, Tennessee and West Virginia combine M.D.'s with D.O.'s (Doctors of Osteopathy).

2. Public Citizen Health Research Group tabulations are of the most serious disciplinary actions by State Boards (Revocations, suspensions and probations) and therefore do not include reprimands and other less serious actions. In addition, many such less serious actions were not reported to FSMB by every state in 1983. We also do not include voluntary surrender of license, approval or denial of requests for change in disciplinary status or actions taken as a consequence of actions by other states. FSMB included these "actions" in their tabulations.

3. Number of non-federal patient care doctors as of 12/82 from A.M.A.: Physician Characteristics and Distribution in the U.S.

M.A.I.M.

RECOMMENDATIONS FOR IMPROVING HEALTH CARE DELIVERY

1. Mandate periodic physical and psychological exams for all licensed and practicing physicians and osteopaths. To include urinalysis and all other tests to detect alcoholism, substance abuse, and all other physical and mental deficiencies.

2. Recertification based on written tests and review of patient records. Also increase the amount of hours of annual continuing education (proof of successful completion should be mandatory).

3. All data on physician performance to be provided to the State Licensing Board for review at time of recertification.

4. Provide for the collection, storage, and review of all malpractice occurances - to include incident reports, suits filed, settlements, and legal proceedings.

5. Require that all settlements be accessible to the public and submitted to all licensing boards. All "gag orders" on settlements should be banned. All attorneys and insurance companies must submit to these licensing boards the results of all settlements and adjudications.

6. Incident reports must be made available and admissable as evidence in a court of law.

7. Public listing of all physician disciplinary actions taken. To include reprimands, suspensions, revocations, and censures.

8. Additional financing of the State Medical Board to increase the administration of all the afore mentioned information. This funding should come from a surcharge on license renewals and/or a percentage of the premium dollar.

9. Mandatory insurance for all physicians including the posting of such coverage in all waiting rooms.

10. Anonymous hot line for reporting of maloccurances.

11. Increased patient education regarding what can happen at a doctors office and in a hospital. This could prevent maloccurances and lower patient expectations.

12. Stronger state regulations regarding physician review and discipline. The number of incidences and suits both pending and settled that trigger review should be lower.

13. If gross negligence or equipment failure occurs causing patient injury or death, it should be a felony for failing to report this to the patient or next of kin.

14. Mandate insurance companies to institute programs for loss prevention.

15. Insurance rating based on individual physician experience, NOT by specialty.

16. Insurance industry regulation and disclosure of all information - to include claims, investments, claim procedures, expenses, et cetera. In addition, insurers would have to annually certify the adequacy of their rates.

17. Prejudgement interest should be tied to either the prime interest rate or an interest rate equivalent to interest earned by the insurer on their reserves.

18. Medical records accessable to patients without requiring fees. Provide for "freezing" records, preventing the tampering and destruction of said records.

19. The administering of medication to patients in physicians offices as well as in medical facilities should be preceded by verbal and written explanation of all side effects and the drugs intended purpose.

20. All drugs and medications deemed ineffective by the FDA should be banned from public use.

21. Incentives should be built into the system to encourage the quick settlement of meritorious cases by insurers and defendant attorneys. The present system of flat hourly fees by defendent attorneys prevents the victim from receiving an expedient settlement.

22. Hospitals, Doctor's offices, and all medical facilities should have complaint forms available for patients to comment on the medical care received. This form should be preaddressed to the State Licensing Board for their collection and review.

23. The amount of hours worked by an intern and physician should be monitored on both a daily and weekly basis in the hope of reducing the instances of poor medical care due to fatigue.

M E M O R A N D U M

TO: R. W. Fleming

RE: MAIM'S Opposition to Senate Bill 470

FROM: MAIM Michigan Citizens Against Incompetent Madicine

DATE: October 29, 1985

CAPS ON PAIN AND SUFFERING: MAIM opposes

MAIM opposes any caps on pain and suffering because we believe that each case needs to be decided on an individual basis and that a cap cannot be legislated since it will prevent people who have some unique form of pain and suffering from recovering adequate damages and there is fear it will serve as a ceiling in all personal injury litigation as well.

The following is a list of non-economic loss: Physical pain and suffering; mental anguish; denial of social pleasure and enjoyment; embarrassment, humiliation, and mortification; disability and disfigurement.

As an example of a situation where caps on non-economic loss would be tremendously damaging; the instance of twins who were damaged during birth and rendered moderately physically impaired but mentally intact. In this situation, the children are not mentally retarded and they will grow up and be able to hold jobs although they will also be wheelchair bound. Because their injury resulted from one birth, they would be limited to one recovery. Two hundred and fifty thousand dollars is not an adequate amount of money to compensate them for their non-economic loss. These children would be acutely aware of their physical pain and suffering, mental anguish, the denial of social pleasures and enjoyments, the embarrassment, humiliation and mortification, disability and disfigurement. Their damage essentially is non-economic, and no one can reasonably claim that it is worth only $250,000.

JOINT AND SEVERAL LIABILITY: MAIM opposes

MAIM's position is in opposition to joint and several liability, but we feel that the problem could be largely eliminated if hospitals, which are the deep pocket, required all doctors with staff privileges to maintain adequate amounts of insurance.

As an example, in most situations, particuarly where children are damaged during birth, the doctor is primarily liable and yet most doctors do not carry more than $100,000 worth of liability insurance. The hospital is named in these cases because they are also liable and because they have the so called "deep pocket." Under current law, the hospital is required if found jointly and severally liable to pay for the portion of the judgment in excess of the doctor's liability limits. If the hospitals do not want to do that, they should require their doctors to have adequate insurance and not attempt to change the law to penalize victims whose doctors had inadequate insurance.

PRETRIAL SCREENING PANEL: MAIM opposes

A Pretrial screening panel composed of three doctors (or composes of anyone for that matter) will extend the time it takes to litigate a medical malpractice lawsuit. As all Plaintiffs are aware, it already takes a long time to go through the Court process, we do not need an extra step in the litigation process. Additionally, we have constitutional arguments against a pretrial screening panel since our access to the Courts should not be restricted by legislation. It certainly not unbiased to have our cases reviewed by three doctors prior to our filing.

In any event, Michigan Court rules of 1985, which were enacted in March of 1985, contain provision 2.114 (e) which was designed to penalize attorneys for filing frivolous lawsuits. It is too early to tell whether or not this Court rule has been effective in reducing frivolous litigation, but it certainly would be unwise to enact additionaly measures when this perfectly adequate Court rule exists.

STATUE OF LIMITATIONS: MAIM opposes

It is MAIM's position that the existing Statue of Limitation which requires the person injured to file lawsuit within two years of the date of the injury or within six months of the date of discovery of the injury, is already overly restrictive. Most people who have suffered a catastrophic loss at the hands of a medical profession do not become aware or oriented to their changed life within a two year period of time necessary to file lawsuits.

The legislation seeks to further limit the injured Plaintiff by requiring the minor Plaintiff to file lawsuit within eight years; the current law allows the child to reach majority before filing. It is not fair to legislate away a minor's right to access to the Courts simply because his parents did not realize that it was necessary for them to do something to protect his rights.

As an example, would be the situation of a mother who is aware that her child was damaged during birth but will not seek to bring litigation against the doctor because of feelings and attachment to the doctor because of his role as family doctor to all of the family members. It is irresponsible for the mother to make that decision for her child who is the individual permanently damaged. If the proposed restrictions go through, the child would lose his opportunity to ever recover for a life long damage done to him simply because his mother would not pursue it on his behalf.

There are other reasons why parents would fail to bring lawsuits on behalf of damaged children as well; for example, situations where a child is severely damaged during her birth, but since one of her parents is in the medical profession, the decision was made not to pursue litigation for fear of damage that would be done to the medical professional's career as a result of attempting to seek recovery through the Court system. It is irresponsible to the severely and permanently damaged child for that decision to be made by the parents who have an interest contrary to the child's.

PERIODIC PAYMENTS: MAIM opposes

It makes no sense for the wrong doer to have use of the Plaintiff's money after it has been determined that the Plaintiff is entitled to receive that money. It will also allow for manipulation of the insurance industries figures in that money that has been committed to an injured Plaintiff will be allowed to draw reserves for benefit of the insurance company and yet will not be reported as part of their gross annual earnings. Additional problems with the periodic payments include the fact that should the wrong doer fail to meet their financial obligation the injured Plaintiff with a favorable judgment would be forced to enforce the judgment at his expense.

COLLATERAL SOURCE: MAIM opposes

MAIM believes that the wrongdoer should not benefit from the injured party's having had health care benefits at the time the injury occurred. The benefits either were paid for out of the Plaintiff's own pocket, or were received by the Plaintiff as a form of compensation for his employment. In either event, there is no justification for the wrongdoer to benefit from that source of income.

We have the additional ideas or thoughts on resolution of the "crisis."

1. Data Base: MAIM believes that the State of Michigan should be keeping an accurate account of all lawsuits filed against doctors, health care facilities, or health care personnel. This base of information should include the type of lawsuit, the resolution of the lawsuit, the frequency that a particular facility or doctor is sued.

2. Intelligent Rate Making: MAIM believes that the insurance company should be required to set their insurance premiums based upon the reality of the risk factor they are insuring. The insurance company could use the data base kept by the State to make judgments on what rate a particular doctor should be paying. As rates are set now, doctors are considered by their specialty as high risk or low risk. MAIM believes that the individual doctor should be considered and not the specialty.

The above two points would have the additional benefit of assuring that the insurance company could project accurate losses per year rather than derive a number unrelated to any factual data as a projected loss.

3. Doctors and Hospitals to Post their Limits of Liability: MAIM believes that the consuming public is entitled to know the limits of liability that their doctor or hospital has prior toseeking services at that facility or from that doctor, therefore, MAIM thinks that limits of liability should be posted in a prominent place for the consumer to review before seeking services.

Ralph Nader *
Press Conference
November 19th, 1985
Lansing, Michigan

The subject this morning deals with a so-called malpractice crisis, that is now under consideration by the state legislature, here as well as in several other states. I think it is important to describe the overall problem first and then come to some recommendations. The overwhelming part of the malpractice crisis is malpractice itself. There is unfortunately a great deal of malpractice going on in the United States, which is attributed heavily to a small minority of physicians, who are not competent to practice medicine and who should be disciplined by the state licensing board.

There is of course no exact figure on how much malpractice there is in the country. There have been a variety of studies, which are extrapolated to the nation, as a whole. I would like to go through some of these for a moment. In 1983, all 50 states in our country, achieved 563 serious disciplinary actions against doctors, who totaled 389,467, who are non-federal patient care doctors in the United States. The estimates of malpractice range from 136,000 to 310,000 cases a year. These are just malpractice instances, not legal cases, in which patients are killed or injured due to errors by doctors. So you compare 563 disciplinary actions against the range of 136,000 to 310,000 instances of malpractice a year. The striking variation amoung states in serious disciplinary action, is not likely due to inherant differences between the quality of medical practice in one state versus another. Rather the main explanation is that some states are much more active than others in disciplining physicians. Although certainly it could be said that no state is doing a good job. Just some states are doing a better job than others. Now if you break this down, you come to the following figures; an average of 1.45 serious disciplinary actions per every thousand physicians, for the whole country. Or, one doctor out of 690 doctors are subject to disciplinary action in any given year. So we come to a problem here first that there is an awful lot of malpractice than is ever perceived by the victim/patients, that is ever brought to lawyers, that are ever brought to court, and are ever brought to trial or to any jury award. That is the biggest single problem today in trying to stop malpractice, which has resulted in death and injury or other harm to the patient. That is where the legislature should be putting its principle focus on. How to reduce the incidents of malpractice and how to compensate the 9 out of 10 victims who never get a cent. Or as some would say, the 19 out of 20 victims who never get a cent. Depending on which study you want to rely on. The citations are in the material you have. In the Public Citizen Research Group Report. Which brings together for the first time the data which are needed in order to make a judgement in this case, in order to inform the public.

Now, I find this report here of the Senate Select Committee on Civil Justice Reform the section on medical malpractice, an intellectual disgrace. For example, it does not tell you how much was paid out in Michigan to malpractice victims in awards and settlements. It does not tell you how much premium income and investment income have flowed into the insurance companies coffers and how much they paid out.

So, without those two key datums, how can a select committee make any recommendations. It is as if the Federal Government was asked to extend loan guarantees to a troubled Chrysler Corporation without getting it's profit and loss statement, without getting it's balance sheet. Instead, these politicians spend their time talking about the litigation explosion. In other words, maybe 1 out of every 20 victims is beginning to think of suing, instead of 1 out of every 50. That might be considered progress in any civilized context. That is, people are realizing that they have been harmed negligently and that the law gives them a remedy and regress. And, then they spend their time giving a few scare stories. And then, they talk about malpractice premiums. Malpractice premiums are what is fueling this so-called malpractice crisis. Ten years ago the insurers in malpractice did the same thing they are doing now. They basically decided to stampede the doctors by increasing their malpractice premiums, so that they, the doctors, will lobby the legislature to restrict victims rights. That is the sequence. The first victims are the doctors who are paying unconscionably high premiums, and then they turn around in their fright and rage and move to restrict victims rights, by legislative action. This is exactly what is going on today.

You can see what the political strategy is behind the insurance companies in three ways; One, they don't release data, that they should release to make their case. Two, they unconscionably increase insurance premiums for doctors and certain specialties without any substantiation actuarially for that increase. Three, they spend virtually none of their resources to try to beef up the policing against incompetent physicians. Which as insurance companies they should have an interest in doing. Just the way a fire insurance company tries to make sure that a building has sprinklers, in order to reduce their loss claims. I could go through the three standards by which this industry should be judged, and they are not meeting the standards. One, they are not engaged in experience rating of physicians. Why should all obstetricians pay equally high premiums when a small fraction of obstetricians have a far greater number of claims against them and other obstetricians have no claims, have a perfectly clean record, and they have to pay for their incompetent peers. If insurance companies, here, were sincere they would experience rate physicians in these sub-specialties. They do not do this. In short the majority of competent physicians are subsidizing the incompetent physicians and the state licensing board is not moving against many of these incompetent physicians. Some years ago the American Medical Association estimated that between 5 and 10 percent of all physicians in this country were either drug addicts, alcoholics, grossly incompetent, infirm, or too old or otherwise disabled to adequately practice medicine. That means that anywhere from 20 to 40 thousand doctors in this country are in that category, and there were less than 600 disciplinary actions in 1983, in all 50 states, against physicians. It is clear also that the insurance companies are paying very little attention to loss prevention. That is where the crisis starts, with the insurance companies.

I want to give you a few additional figures which will put this whole problem in a little perspective. I have not been able to locate how much has been paid out in Michigan last year in awards and settlements to malpractice victims. Has anybody here? If not, the question is, Why not? Second is, I have not been able to locate how many people have actually been paid. Those datum are available. But if you look at the coverage, if you look at the Senates performance, it is pretty hard to find them. But, they should be brought out, if the authorities or the insurance companies do not have that data, do not aggregate it, they shouldn't be given the time of day for their so-called complaints. In 1983 as best as we could calculate, nationwide, 16,400 people were awarded payments through verdicts or settlements in the entire United States. Population 240 million. These 16,400 people, were awarded a total of 1.7 billion dollars in 1983. 1.7 billion dollars is less than 4 percent of physician income. 1.7 billion dollars is less than 1/2 of 1 percent of the entire cost of health care in the United States. Is that too high a price to pay to generate deterance for greater physician competence and safety and care. 1.7 billion dollars for a health care bill that was over 300 billion dollars. Less than 1/2 of 1 percent. That is what I mean by putting it in perspective. In 1978 the Carter administration came out with a report which estimated that this country was losing 4 billion dollars a year because of unnecessary x-rays. ordered by physicians and dentists. 4 Billion dollars a year. I didn't hear anything about an x-ray crisis. This is 1.7 billion dollars, for the entire country. I suggest that you try and get the data broken down for Michigan. Some of the references in the Public Citizen Report should be of assistance to you.

I want to give you some examples of what we found in other states. There is a malpractice crisis alledged in Massachusetts. We went up to Massachusetts and found the following; About 550 people got awards or settlements due to malpractice experiences, in the state, in the last year that was recorded, 1983. 60 million dollars was paid out to those people. The Joint Underwriting Association, which is kind of like a monopoly providing malpractice insurance in Massachusetts, paid out 60 million dollars, they have 300 million dollars in reserve for future years. They have the equivalent of 5 years already socked into the bank earning 30 million dollars a year interest. Nevertheless they moved to stampede the doctors by sharply raising malpractice premiums, especially on certain specialties such as obstetrics, in order to get the requisite pressure on the legislature. The Joint Underwriting Association in Massachusetts hardly lifts a finger to police against incompetent doctors. Now listen to this, the Massachusetts Medical Society presents a 144 page brief on the subject and they underline one very interesting observation. They say the insurance company, writing malpractice in this state, has no incentive for efficiency and no incentive for loss prevention. Because, the more they charge the more they can get. They have got a monopoly. There isn't much competition in this industry to begin with. There is only two or three companies which lock up this state. What is needed in this area is not tort reform. What is needed is insurance reform. What is needed is regulation of the insurance industry. And, I would put that right up at the top of the list, instead on restricting the rights of victims, instead of restricting the rights of personal

injury in the state of Michigan. The state legislature should regulate the premiums that are charged to victimize doctors by avaracious insurance companies. Bring those premiums down to sound actuarial basis and move to increase the law enforcement at the state level, to weed out incompetent doctors. The doctors who are too ill, or too alcoholic, or too drug addicted to practice medicine adequately.

I have a number of other recommendations. First, the state licensing board which regulates doctors should be funded by a surcharge on annual medical license fees, so the doctors themselves fund their own policing board. Second, there should be stronger state doctor disciplining legislation. This has already occurred in Florida, Kentucky, and a number of other states, which have strengthened both the budget and the powers of the state licensing and disciplinary functions. Third, insurance companies should experience rate doctors within a sub-specialty. There is no reason that the many excellent physicians who have not had adverse malpractice adjudication or settlements against them should have to subsidize the premiums of their malpracticing colleagues, who now pay the same as they do. Fourth, all attorneys and insurance companies should be required to immediately turn over to their respective state medical licensing boards, the results of settlements or adjudications which result in the payment of claims to injured patients. At present, the terms of settlements often prevent attorneys from supplying this information in the file of the involved doctor. In other words the settlements are secret. And so publicly, including the state licensing board, it is not known which doctors have paid out for what kind of claims. The data collection is very primitive. Fifth, the data on doctors performance should be provided the licensing board, if there are professional review organizations in this state or peer review organizations, the data collected on doctors performance, taking care of Medicare and Medicaid patients should be made part of the doctors file, at the state licensing board. Sixth, there should be periodic recertification of doctors, based on written exams and an audit of doctors performance, such as medical record review. We have all had experiences with doctors who are practicing 1940 medicine. They got out of Medical School in 1940 and they are still practicing that kind of medicine. They are not up to date, and they need to be recertified. In 1980, we put out a book called Pills That Don't Work, listing 610 widely prescribed drugs daily by physicians, that are totally useless and ineffective for the purposes for which they were prescribed. According to scientific review panels of the Food and Drug Administration. What does that tell you about competent doctors. I just heard of a person, the other day, who was prescribed a drug for back pain, which is totally useless for the purpose for which it was prescribed. Yet the doctor was still prescribing it. Those are my recommendations.

In response to doctors pressures for restricting the victims rights, we should regulate the insurance companies and regulate against incompetent doctors. Those are the two most important remedies which should be pursued. There are a number of other changes that are reasonable. One is a requirement, that says, that any malpractice suit has to be certified as worthy by one physician. If you can't get one physician to certify a malpractice ease as being worthy, you can't usually bring the case

anyway. Who is going to testify?

Now, I noticed that this committee was very concerned about the following; That in the tri-county area of Wayne-Oakland-Macomb the number of medical malpractice suits increased from just over 200 in 1970 to nearly 2200 in 1984. What does this tell you? That doesn't tell you how much has been paid out. It doesn't tell you how many of these cases have been thrown out of court, or never reached a jury. It doesn't tell you that only 30 percent of all malpractice cases reach a jury verdict, come out in favor of the plaintiff. The doctors win 70 percent of the time. It doesn't tell you that the insurance companies are raking in a far greater percentage of premiums now than in 1970. It doesn't tell you that it is a healthy thing for people to realize that finally they have got rights against malpracticing physicians and we should applaud arising expectations by the public that they can use the law to defend themselves and to adequately compensate for their injuries. Why do we look at the expansion of personal injury rights and remedies and compensation, in this country, as if it is something bad. It is just as important for that to expand as it is for civil liberties to expand, as it is for people to pursue their civil rights. Can bodily rights be any less important under a system of justice against negligent practitioners. Or the producers of harmful products. Than the recognition and utilization of the law for civil rights and civil liberties purposes. I think the burden of proof should shift to the perpetrators who harm people through malpractice and incompetence, not to victims who are trying to eleviate some of their pain and suffering and use the courts to generate deterance so that doctors are more careful, so those who should not be practicing medicine should no longer have the license to do so. I find most offensive the 250,000 dollar cap, being proposed for pain and suffering, by the state legislature, in the Senate. Imagine, somebody who is a victim of a malpractice surgery and for the actuarial life of 40 or 50 years goes through excruciating daily pain and suffering, every waking minute, and the lawmakers here in Lansing are telling that victim that he or she under a court of law, with the burden of proof on him or her, can not strive to get an award for that pain and suffering above 250,000 dollars, in an inflation ridden economy. For a life time of pain and suffering, while that same legislature allows insurance executives of the insurance companies to make the skies the limit. To make 750,000 dollars or a million dollars a year without pain and suffering. So if there are going to be any restrictions on what victims can recover, why shouldn't there be restrictions on insurance company executive level of compensation? Why shouldn't there be restrictions on insurance premiums by companies writing malpractice insurance? If there are going to be any restrictions on lawyers fees for the plaintiff, why arn't there restrictions on corporate attorney fees, in those fancy Detroit lawfirms? You see where the bias is, inother words. I am opposed to any cap. The judges and courts of the land are well equiped to decide it, and if they decide an outragious verdict, it can alway be remitted by the trial judge or by the appellate court. It is not easy to go through these cases and win.

* This Press Conference was Sponsored by M.A.I.M. Michigan Citizens Against Incompetent Medicine

Ralph Nader *
Press Conference
November 19th, 1985
Lansing, Michigan

Question & Answers

Question: Are you saying that the insurance companies are the ones who actually stage what is going on now... This crisis, just to make more money?

Answer: Yes, without any actuarial basis, without any interest in reducing their loss, by prevention and policing the doctors. The insurance companies, by skyrocketing unfairly the insurance premiums, are victimizing doctors in order to turn the doctors into lobbyists before the legislature, to in turn restrict victim rights under the law of the state of Michigan.

Question: You said in the back of the room earlier that you feel the insurance companies were looking for an industrial state with, I believe your word was a cowardly governor of incompetent Michigan. Is that what you are saying, that Governor Blanchard is cowardly when it comes to this?

Answer: I think Governor Blanchard has a record of Kowtowing to powerful special interest groups, starting with the auto industry in this state, and I think that the insurance/doctor lobby is a powerful interest group and I don't look with great optimism at his stating that he will veto any bill that restricts victims rights by shortening statute of limitations for infants who are subjects of malpractice, or putting a 250,000 dollar cap on pain and suffering awards.

Question: In other words, you are saying the whole thing, the caps, all this, doesn't matter, the idea is the fact that the doctors should do the enforcement, isn't that your bottom line?

Answer: The insurance companies can not get anything through this legislature by themselves, because they can not substantiate their case. So they create a class of victims, called doctors, by skyrocketing the malpractice premiums without actuarial basis. And then, the doctors become lobbyists for the insurance companies, to restrict victims rights.

Question: Should doctors be licensed tighter? Is that what you are saying?

Answer: Yes, the biggest problem in this so-called malpractice crisis is the incidents of malpractice. And, the way to reduce the malpractice is for the state licensing board to have more resources and tougher enforcement power, to take away the license of doctors who are incompetent and shouldn't be practicing medicine, in the state of Michigan.

Question: What is the motivation behind the insurance companies for skyrocketing these costs? What are they after?

Answer: What they are after is more immunity, by restricting victims rights. There will be fewer lawsuits, fewer settlements and the insurance companies can laugh all the way to the bank. With bloated insurance premium collections, that they are taking from their doctor customers.

Question: So they are just after higher profits?

Answer: Yeah, why should that surprise anybody. The insurance company is a cash cow, instead of being a safety bull. They should be a safety bull, prevention, loss control, safety, instead it is a cash cow.

Question: To what degree are attorneys a part of this probem?

Answer: They don't bring enough cases. That is, they bring the big cases, they should also bring the small cases. That is what they should do.

Question: Well, the attorneys are also accused of bringing too many cases.

Answer: I wouldn't say that one out of twenty malpractice instances, in this country going to an attorney is very excessive. What we basically need is a framework where those 19 out of 20, or 9 out of 10, depending on which study you want to rely on, get some sort of award. That is where the concern should be. The vast majority of victims of incompetent doctors who don't get a penny for their injuries and for their pain and suffering.

Question: So the attorneys share no blame in this alledged crisis at all?

Answer: The only blame they would share is if they took too high a percentage of the award. I think one third should be the highest any attorney should take under contingency fee. You should remember that they lose 2 out of 3 cases in court, for which they receive not a cent. But the attorneys for the insurance companies, bill by the hour, and always get their money.

Question: You say, you find the 250,000 dollar cap reprehensible. Do you believe in caps at all then?

Answer: I do not believe in caps, because I believe in a case by case adjudication, by courts which are characterized as having a predominate number of conservative judges and conservative appellate structure. It is very difficult to win a malpractice case. And a few big wins are publicized by the insurance companies to camoflage the facts, which are, that they are taking in far more money than they are shelling out, and they are not experience rating doctors.

Question: Is the malpractice crisis, as it is called, is that the systematic of the overall insurance industry where we see liability insurance being raised and cancelled all across the United States, Why now?

Answer: Every ten years they seem to have the cycle, they dramatically increase premiums in the liability area, and then they get a huge windfall of profits, their profits go up. Right now the stock brokers in New York are saying the number one industry buy for stocks, is the property casualty insurance industry. You can go to any stock broker and you will see a high buy recommendation, because their profit rates now are going to skyrocket in the next two years. Then they start writing everything in sight, this happened in 1975. They had a crisis, they raised the premiums, their rates of return on net worth started going up 15 - 30 percent and by about 1980 - 1981, they were writing anything insight. They even wrote retroactive insurance after the MGM hotel fire in Nevada. They wrote retroactive fire insurance. Then their rates started going down. Last year the casualty insurance companies said that they lost 3.5 billion dollars. That is because they don't crank in the requisite investment income. The General Accounting Office report, which you could obtain, and the U. S. Congress states that they did not have a good year, last year. The whole industry. But they made 3 percent profit on net worth. Next year it will be up to 10, 12, 15 percent or so. It may hit 30 percent, according to one stock brokers report, by 1987. And then, you will have the cycle all over again. So we have got to stabilize this process and stop having insurance companies turn itself into a cyclical industry. By the way, I would caution anybody in the state of Michigan, to entertain seriously the arguements, by some state legislators here in Lansing, that they want to turn Michigan law into the Indiana analogy. Indiana is the worst state in the country, in terms of disrespecting the right of injured people. If an infant, in Indiana, is killed by negligence, about all you can collect are burial expenses. Indiana is the Culliny in the country, in this area. Never use Indiana as a measurement. It is enough that there are states in the union who disgrace their historical pretentions, without adding Michigan to the list.

Question: I was told last month, during the rally here ... that two of the largest providers of malpractice insurance in the state are owned primarily by physicians, and therefore we could eliminate any real ... or scam or anything like that. Because, basically the money is coming out of the doctors pockets.

Answer: Well first of all, the doctors don't control them. They may be of, but they are not by. We have seen that many times, groups that are not controlled by their members. Try savings and loans mutual. Secondly, there is one concern they have and this is where there is reasonable disagreement, they exagerate their reserves. For example, They say, we need a billion dollars in reserves, and some actuarial will say, you only need 250 million, and someone else will say,

you need 500 million. That is where the problem comes from. It isn't the payouts today or this year, it is what they are estimating for reserves. That is why I mentioned Massachusetts. 300 million dollars in reserves and they want to triple and quadruple malpractice premium rates for certain specialties in Massachusetts. They paid out 60 million in 1983. So this is the power of the industry. This is the only industry in the country that can decree its level of loss. Simply by exagerating its loss reserves. How much they sink away for the future. That is what you want to look carefully at. They are also pushing for a claims made policy form, so the only time you can collect is when the policy is in force. Rather than, you get a policy for 1985, something happens that is negligent and you discover it three years later, but then you no longer have the policy, you wouldn't be able to sue. Now this is being pushed by Lloyds of London and the reinsurers of U.S. domestic insurers. And alot of the problem starts with the offshore reinsurers who are twisting the arms of the domestic reinsurers to in turn twist the arms of the legislature in order to revise the terms of the traditional insurance policy, into a claims made mode.

Question: Do you take issue with the insurance bureau of this state in that it requested the insurance companies to raise their rates?

Answer: First of all you have got to get the data out, in order to see what the situation is. This is not something people could say off the cuff. You have got to have actuaries actually come down and examine the data. But, I do think there should be rigorous regulation of premium rates for malpractice, the way there is legal regulation for auto insurance rates in many states. ... I can tell you that apriority, that any 5, 7, 8 fold increase in malpractice rates for a physician sub-specialty is a wild politically inspired rate. Simply, there is never any justification for that kind of increase. Let me just give you an illustration. Last year the insurance industry got 3 percent on net worth for the property casualty industry nationwide. It would take a 5 percent average premium increase to bring that industry up to 15 percent return on net worth, which is a good return. A 5 percent increase in what consumers pay the insurance companies would bring them to a normal rate of return. There is no way they could justify 6, 7 fold increases in premiums.

Question: Are you saying that it is unfair?

Answer: Of course, it is a trememdous gouge.

Question: How do you rate Michigan problem in the scope of the entire malpractice problem across the country?

Answer: The same claims are made in New York, Massachusetts, Texas, Florida.

Question: There are problems with the number of cases and so on and so forth?

Answer: Certainly there are more claims per population here in Michigan than there is in a state like Mississippi, but not more than in a state like Massachusetts, New York or Florida, or California or Texas. And there are more claims than in Indiana, because, Indiana closes you off. It is very difficult to win against a doctor in Indiana.

Question: If Indiana law is the absolute worst, is there any states which Michigan could look at as a model? In terms of the law?

Answer: Michigan law is alright, the way it is. You should want to keep it the way it is..

* This Press Conference was Sponsored by M.A.I.M. Michigan Citizens Against Incompetent Medicine

DEPARTMENT OF LICENSING AND REGULATION

CONCEPT	PURPOSE	IMPACT ON MALPRACTICE	RESOURCES
Review and investigation of the malpractice suits filed with the Insurance Bureau of the Department (Forms A & B). Currently, the complaints received by the Bureau do not result in many administrative complaints being issued against practitioner for cases involving "level of care". The medical board administrator position which was created and funded beginning 10-1-85, will be responsible for developing a "system" for reviewing the 2700 malpractice forms which are filed per year. (Form A) as well as determine the value of the Form B reports (settlements). The "system" will include coordination between Bureau of Health Services, Insurance Bureau, Department of Public Health, and the courts. It will also be necessary for suggestions for revision of the computerization of the malpractice forms (A's & B's) within the Insurance Bureau to be made by the medical board administrator.	The purpose of the review is to set the appropriate criteria to enable the investigation and subsequent issuance of administrative complaints against those practitioners who are violating the Michigan Public Health Code.	If the bureau is successful with the removal from the system of those licensees who are the subject of numerous malpractice suits because of actions below acceptable and prevailing standards of practice, it would certainly be helpful but how much of an impact the effort will have is unknown at this time. However, if the bureau is able to change its investigation focus, this concept will allow for additional resources to be placed on malpractice investigations.	Bureau of Health Services would need 2 additional investigators, 1 analyst, and 1 clerical support position. The administrative law section within the department would need 1 additional hearings officer and 1 clerical support person. The Department of Attorney General would need 1 or 2 additional assistant attorneys general.

CONCEPT	PURPOSE	IMPACT ON MALPRACTICE	RESOURCES
Continuing Education Audit unit within the Bureau of Health Services to audit licensees of the six (6) boards having the C.E. mandate. The unit would be responsible for issuing complaints against practitioners found not be in compliance, assist the boards with developing criteria for approving C.E. courses and develop C.E. course attendance monitoring. The unit's activities may require amendments to the Public Health Code to strengthen this function.	To ensure practitioner compliance with C.E. mandates, identify and address the "problem practitioner" (i.e., dated practitioner/ mental or physical inability to practice/chemical dependent practitioner).	If the type of problem practitioner identified in the C.E. audit process is cross-referenced with the malpractice form information, the potential for impact is present.	Present resources within the Bureau of Health Services will be sufficient to initiate the program.

CONCEPT	PURPOSE	IMPACT ON MALPRACTICE	RESOURCES
To divert "non-level of care cases" away from the department to enable the existing resources within the bureau to investigate the malpractice type cases and provide for rehabilitation of practitioners. The allegations which would be subject to being diverted from the bureau/department would be: *- chemical dependency - mental and physical inability to practice - false advertising, unethical business practices, misrepresentation to the consumer The effort would be accomplished either in conjunction with the professional society(s), an independent appointed group, or a combination of both proposals. The peer review entity would be established in each county or by region to receive and resolve allegations against medical doctors (pilot program for other professionals) The Public Health Code would be amended to grant the peer review entity authority to investigate and resolve complaints, have immunity for the peer review entity, establish cooperation between	To create a mechanism for identifying and rehabilitating the practitioner who is suffering from chemical dependency and/or the physical or mental inability to practice without using limited bureau resources. The concept would also allow the resolution of certain types of complaints (i.e., unethical business practices) at the county or regional level without using limited bureau resources.	The percentage of malpractice suits filed against practitioners who are chemically dependent or physically or mentally unable to practice is currently unknown. The diversion of these allegations away from the department will enable investigation resources to be used on malpractice cases.	Funding for per diem, travel and administrative support services for the panels will be necessary. The bureau would need one additional analyst position to coordinate the activities of the panels.

* - Model AMA Proposal attached

CONCEPT	PURPOSE	IMPACT ON MALPRACTICE	RESOURCES
the peer review entity and the boards, joint review of cases by board and the peer review entity sharing of statistical information between boards and the peer review entity, confidentiality of program records and mandatory reporting.			
Repeal certain sections of the Michigan Public Health Code within Section 16221.	Remove sections which may be addressed by agencies other than the bureau or outdated sections that are no longer applicable for enforcement.	If the bureau is no longer obligated to investigate certain sections of the PHC, it would be able to direct its resources to investigate malpractice cases.	Additional resources would not be needed for implementation of this concept.

Excerpts from "A Report on Civil Justice in Michigan" by the Senate Select Committee on Civil Justice Reform, present to the Senate Sept. 26, 1985

-- INTRODUCTION --

"I'll sue!" has become such a standard response to controversy that Michigan court dockets are backlogged, lawsuit counts are mushrooming, awards are setting records and the general public is being seriously affected in both tangible and intangible ways. Reduced access to full health care services, higher property taxes, reduced local government services, a battered business climate and cost-prohibitive liability insurance affects every citizen.

Liability has reached epidemic proportions and presents an emergency situation to the Legislature. There is little time for delay in addressing this crisis. Because of this looming consumer problem, the Senate Select Committee on Civil Justice Reform has conducted public hearings around the state of Michigan this summer to evaluate the extent of the liability problem and seek insights from the experts in devising legislative solutions.

The Select Committee consisted of three subcommittees addressing three major aspects of the problem: Medical Malpractice, Governmental Liability, and Dram Shop Liabiity. Though virtually every other business concern -- from day-care centers to horseback riding stables to law practices -- is affected by liability or malpractice costs, doctors, bar owners and civil governments face perhaps the biggest challenges of the day.

Before legislative findings and solutions are presented in this report of the Senate Select Committee on Civil Justice Reform, a description of the problem in its three specific topic areas is presented in this introduction.

REPORT AND RECOMMENDATIONS ON

MEDICAL MALPRACTICE

BACKGROUND

The Subcommittee on Medical Malpractice, in conjunction with the Senate Judiciary Committee, has held six meetings around the state to take testimony from any persons or organizations interested in or concerned about the various problems related to medical malpractice. These hearings were held on July 24 in Traverse City, July 26 in Marquette, August 26 in Muskegon, August 27 in Pontiac, September 16 in Saginaw and in Adrian. These meetings were preceded earlier this year by a series of Senate Judiciary Committee public hearings on this topic and by last year's Judiciary Committee hearings examining legislation on medical malpractice, sponsored by Senator McCollough (Senate Bill No. 224).

Further, staff has had extensive contact with representatives of the State Bar, the Michigan Trial Lawyers Association, the Michigan Hospital Association, and the Michigan State Medical Society.

Persons and organizations representing the various interests impacted by the problems regarding medical malpractice have made strong and valid arguments in support or opposition to the recommendations contained in this report. The Committee is sensitive to the rights of victims injured by the negligence of health care providers. These injured parties must be fairly compensated.

Based on the data presented to this Committee, it is clear that Michigan is currently being faced with a malpractice crisis. This crisis is manifested by the large increase in premiums for insurance against malpractice losses. These increases threaten to result in the lack of affordable insurance and even

the very availability of insurance. For example, the three insurance companies that write malpractice policies in Michigan have raised their rates by an average of at least 49 percent last year.

In turn, this poses serious questions about the continued availability of certain medical specialists, such as neurosurgeons, ob/gyns and orthopedic surgeons, and the availability of treatment for certain high-risk patients, such as prenatal care for medically indigent in the inner cities. For example, just this summer orthopedic surgeons and neurosurgeons in Flint have refused to treat certain high-risk patients. Concurrently, ob/gyns in Muskegon have reduced the number of babies they are delivering. A survey by the Michigan State Medical Society found that about two-thirds of Michigan's ob/gyns either have stopped delivering babies, have reduced their obstetrical services, or plan to reduce their services.

Another survey by the Michigan Academy of Family Practice found that Michigan's family physicians are also quitting specialized services because of the threat of lawsuits. Any reduced services would have a disproportionate impact on individuals living outside large cities because over half of the state's family practitioners are from rural areas or small towns.

The increase in medical malpractice premiums can be correlated to a recent explosion in malpractice litigation, exemplified by an increase in the number of claims filed and the increase in the amount of these awards. One Michigan insurance company reports that the frequency of malpractice claims has risen from 10 per 100 physicians in 1979 to 25 per 100 physicians in 1984. In the Metropolitan Detroit tri-county area, the number of malpractice suits filed per year has increased by 1100 percent over the last 14 years. Additionally, the average payment per claim for one insurance company has risen from an average of $10,000 in 1980 to $50,000 per closed claim in 1985.

Yet, it is clear that these increased premium costs are not caused by an insurance "conspiracy." If it were an insurance crisis, how can one explain that claims on a percentage of policyholders is twice as high in Michigan as in Ohio or Indiana. Even more importantly, at the same time Michigan has experienced an increase in both the frequency and severity of malpractice claims, it has also had an increase in the quality of health care services and a decrease in utilization. Unfortunately, for the critics of reform, this refutes the easy answer that it is merely an insurance problem.

Rather, Michigan is found with a real malpractice crisis which is a complex legal, medical and insurance problem.

Based on these considerations, the Committee submits the following recommendations:

1. Pre-Trial Screening Panel

Recommendation

MEDICAL REVIEW PANELS ESTABLISHED BY STATUTE TO DETERMINE IF THE HEALTH CARE PROVIDERS FAILED TO COMPLY WITH THE STANDARD OF CARE. THESE PANELS MUST BE USED AS A CONDITION PRECEDENT TO FILING A LAW SUIT. THE OPINION OF THE PANEL IS ADMISSIBLE IN EVIDENCE. IN ADDITION, THE CLAIMANT OR HEALTH CARE PROVIDER MAY REQUEST THAT A PANEL MEMBER TESTIFY AT THE TRIAL. IF REQUESTED, THE MEMBER MUST APPEAR AND TESTIFY.

Justification

This recommendation is to enact the Indiana pre-screening panel system in Michigan. This proposal will enforce the effectiveness and efficiency of processing medical malpractice cases. The mandating of pre-screening of potential malpractice actions by a panel of doctors will help to weed out frivolous actions and will aid in the prompt settlement and payment of claims when medical malpractice has in fact occurred. It is necessary for this panel to be composed of doctors because only physicians can best determine whether the appropriate standard of care was breached.

In handling malpractice actions, too much time, money and other resources are spent on litigation. One study indicated that legal fees and expenses cost more than is actually paid out to injured parties. For example, in 1984 legal fees and costs composed 52 percent of PICOM's expenditures, while the injured patients' share only amounted to 40%. These high costs result because both plaintiff and the defense attorney wait too long to settle meritorious actions, deal with too many frivolous lawsuits and defenses, and litigate many cases that should not be tried.

This reform should have the impact of eliminating many frivolous actions and defenses. Nationally, 75 percent of all medical malpractice cases are closed without payment. PICOM indicates that about 50 percent of all malpractice cases are dismissed without either a trial or payment of indemnity. Additionally, Medical Protection Insurance Company reports that 13 percent of all malpractice lawsuits are closed without payment and without going to trail. This seems to indicate that a number of frivolous malpractice claims are being filed. However, even in those cases, the defendant must still pay the cost of legal defense. These costs can amount to thousands of dollars per case and have risen by over 70 percent in the first three years. By giving an early indication that no malpractice has occurred, the pre-screening panel would aid in eliminating the costs resulting from the handling of frivolous lawsuits.

On the other hand, it would also speed up payment to the injured party with legitimate claims. By establishing at the outset that negligent treatment had occurred, this system creates an incentive for defendants to settle these cases quickly. This process has demonstrated that ability to speed up the disposition of these cases. For example, in Michigan it currently averages 36 months from the filing of a lawsuit to the final resolution, but in states with a pre-screening panel, the average is only 24 months. In fact, in Indiana, after which act this proposal is modeled, it only takes 18 months -- one half

of Michigan's time. Needless to say, the longer it takes to close a case, the more it will cost in legal fees and costs to handle it. While it is impossible to determine the exact amount that this will save, it is safe to say that it will be significant. The cost reduction can be achieved by merely making the system more effective and without reducing the amount to be paid to the injured party.

2. Statute of Limitation

Recommendation

AMEND THE PRESENT STATUTE OF LIMITATION REGARDING MINORS SO THAT FOR MEDICAL MALPRACTICE CLAIMS THE STATUTE IS TOLLED UNTIL THE CHILD REACHES 6 YEARS OF AGE INSTEAD OF THE CURRENT 18 YEARS.

Justification

This reform is an attempt to get at the problem created by the "long tail" on medical malpractice claims. In insurance terms, the length of time between the accident date and report date is referred to as the "tail." The long tail in medical malpractice is a major difficulty in setting actuarially sound rates.

Under current Michigan law, medical malpractice lawsuits arising out of the birth of a child does not have to be filed until two years after the child's 18th birthday, or in other words, until 20 years after the occurrence. This reform would attempt to shorten that 20-year tail to an 8-year tail. Yet, with the retention of Michigan's 6-month discovery rule, this would not cut off a legitimate claim by a victim for an undiscoverable injury. The rationale behind choosing the age of 6 is that by that time most, if not all, children have gone to school and been given developmental tests. While the parents, especially in the case of an only child, may not be able to recognize that the child is suffering from a disability, the professionals, such as teachers and counselors, who deal with a number of children, should be able to detect a

deficiency. Since the statute would not run out until age 8, this would mean that the child would normally have at least 3 years of schooling before the statute would bar their claim. This should give more than enough time to timely file an action based on an injury.

To demonstrate the extent of the malpractice tail in Michigan, the average malpractice claim is not even reported until 2 years after its occurrence. The Michigan Insurance Bureau states that the average claim is not paid until 5 years after occurrence, although payments may extend many decades beyond the occurrence. The Pennsylvania Report on Medical Malpractice Insurance estimates that half of medical malpractice claims will not be paid until 7 years after occurrence.

The Medical Protective Insurance Company indicates that in 1984 it opened up 33 new cases that were more than 10 years after the service date, of which 16 were before 1970. They claim that they just can't have these 15-year-old cases coming in because they cannot accurately price their risks. This long tail causes malpractice insurance companies to maintain large asset and reserve balances to cover claims that may arise 20 years down the road. It is this large reserve for these future unfiled claims that lead to the controversy over whether insurance companies are ripping off the doctors.

The experience of the Pacific Indemnity Company presents a good example to comprehend the length and breadth of the medical malpractice payment tail in Michigan. In 1977, Pacific Indemnity ceased writing malpractice policies in Michigan. In the 6 years since that time, they have paid out over $39 million in direct claims without any additional premium income. Of this amount, claim payments for 1983 and 1984 exceeded $11 million, and an estimated $7 million in claims remain unsettled. This dramatically indicates that large reserves are a necessity for medical malpractice insurers.

This reform, by cutting 12 years off the malpractice tail for the claim of minors, should help to significantly alleviate this problem. Allowing the insurance companies to get a better handle on liability expenses should result in the setting of actuarially sound rates. In turn, this should eliminate both the need for and the controversy surrounding the large insurance reserve accounts.

3. Limitation on Non-Economic Damages

Recommendation

A. ENACT A $250,000 LIMIT ON THE AWARD OF NON-ECONOMIC LOSSES.

B. REQUIRE THE FACT FINDER TO ITEMIZE THE AMOUNTS AWARDED TO THE CLAIMANT INTO PAST AND FUTURE DAMAGES; AND INTO ECONOMIC AND NON-ECONOMIC DAMAGES.

Justification

A substantial portion of the verdicts being returned in medical malpractice cases are for non-economic losses, such as, pain and suffering. There is a common belief that these awards for non-economic damages are the primary source of the overly generous and arbitrary malpractice payments. This is because these claims are not easily amenable to accurate or even approximate monetary assessment. As a result the translation of these losses into dollar equivalence is a very subjective process.

There is some data suggesting that juries are compensating medical malpractice injuries at a higher level than the same injury caused under different circumstances. For example, a Rand Corporation study indicated that malpractice awards for a comparable injury were larger than judgments for dram shop cases and automobile accidents.

A cap on permissible "non-economic" damages will help reduce the incidence of unrealistically high malpractice jury awards, yet at the same time it would protect the right of the injured party to recover the full amount of economic

losses, including lost wages and medical expenses. A number of states, most notably California and Indiana, have enacted limits on non-economic damages in malpractice actions. A 1982 Rand Institute for Civil Justice report found that states which have adopted caps have experienced an average drop of 19 percent in the severity of awards within two years of enactment. This might lead to a stabilization of the medical malpractice insurance premiums. In turn, this could lead to lower premiums and reduced health care cost to consumers and would guarantee the availability of medical services to all consumers.

While these caps are susceptible to constitutional challenge based on equal protection grounds, these limits have been upheld in a number of states, most notably the trend-setting state of California. Its Supreme Court has upheld a $250,000 cap on non-economic damages stating that this limitation was rationally related to a legitimate state interest by reducing malpractice costs for medical care providers and assuring the viability of the professional liability system. Furthermore, the Ninth Circuit of the United States Court of Appeals has also upheld the constitutionality of the California non-economic loss cap in a recent July 1985 decision. The Court of Appeals held that the California statute was supported by a rational basis and thus, did not violate the equal protection clause of the United States Constitution. This is because the reduction of medical malpractice insurance premiums is a legitimate state purpose, and it is reasonable to believe that placing a ceiling on non-economic damage would help reduce these premiums.

Accordingly, based on these rulings from a trend-setting state, there is a high probability that a cap on non-economic damages in medical malpractice cases will be held to be constitutional. Unquestionably, this type of cap will have a significant impact in reducing the amount of malpractice payments without denying the injured party's reimbursement for out-of-pocket losses.

4. Joint and Several Liability

Recommendation

A. ABOLISH JOINT AND SEVERAL LIABILITY FOR DEFENDANTS WHOSE NEGLIGENCE IS LESS THAN 50 PERCENT.

B. REQUIRE THE FINDER OF FACT TO APPPORTION RELATIVE DEGREE OF FAULT BETWEEN PLAINTIFFS AND DEFENDANTS AND ALSO ASSIGN A PERCENTAGE OF LIABILITY AMONG THE VARIOUS DEFENDANTS.

Justification

The abolition of joint and several liability and the institution of liability on the basis of comparative fault is the emerging national trend in liability law. The Supreme Court of Michigan took the first step toward this system of comparative fault in 1979 by adopting comparative negligence between the plaintiff and one or more defendants. Limiting liability to the degree of fault attributable to a particular defendant is the logical and fair extension of this comparative approach.

With a system of comparative negligence, strict joint and several liability is no longer justified.

Joint and several liability dictates that when a person is injured by the conduct of several people, the liability is indivisible; i.e., the injured person can collect the entire judgment from any of the wrongdoers. The doctrine has evolved over the centuries by the courts. Historically, jointly liable tortfeasors were those persons who by common design, acted together to injure the plaintiff. The modern concept of joint and several liability attributes liability to any defendant whose conduct has contributed to a single indivisible injury -- a much broader concept.

The question of modifying joint and several liability has arisen upon the adoption of comparative negligence. Until 1979, the doctrine of contributory negligence prevented a plaintiff who was negligent in any degrees from recovering from a defendant unless the defendant committed gross negligence.

This was a harsh doctrine that made marginally negligent plaintiffs bear the entire burden of his or her loss or injury.

In 1979, the Michigan Supreme Court adopted the doctrine of pure comparative negligence in place of contributory negligence. Under this doctrine, the plaintiffs damages must be reduced to the extent of the plaintiff's own negligence, but the action is not barred by that negligence.

The doctrine of joint and several liability, therefore, historically operated in the context of contributory negligence where the plaintiff was legally without fault. The doctrine was intended to make whole an innocent plaintiff and place the risk of one of the several defendants being insolvent on the other wrongdoing defendants.

With the system of comparative negligence, fault is required to be apportioned between the plaintiff and defendants. Therefore, the concept that fault or the cause of the injury is indivisible does not apply. Also, it is not necessarily the case that the plaintiff is innocent. On the contrary, the plaintiff may be more negligent than the defendants.

This proposed modified joint and several rule is an attempt to balance the equities based on the concept of relative degrees of fault. It is an attempt to solve the perceived problem that defendants with deep pockets are paying a disproportionate share of the verdict even though their degree of fault is relatively minor.

If the solvent defendant is responsible for one half or more of the negligence, then he or she should still be liable for the entire amount of damages. However, if the defendant is responsible for less than half of all defendant negligence, then that defendant would only be liable for his or her own degree of fault. This represents an attempt to assign liability amount co-defendants based on their degree of fault instead of the size of their pocketbooks.

Under this proposed scheme, a defendant who is only 5 percent negligent would not have to pay for 90 percent of the damages, but rather would only have to pay for his or her own degree of fault. Basic fairness requires that a defendant who did not cause the majority of the damage should not have to pay for the entire loss. This is a step towards basing each defendant's liability exposure on the degree of responsibility. Yet, it continues to assign the risk of uncollectibility to the defendant who is responsible for the majority of the negligence.

This proposal will have a major impact on the liability exposure of hospitals, who are normally the malpractice defendant with the deepest pocket. For example, Henry Ford Hospital estimates that $565 from every patient's bill goes to cover malpractice insurance. This amount has increased by 200 percent over the last two years.

Fourteen states have recently limited or abolished joint and several liability. This particular type of revision was enacted by statute in Iowa, 1984 Act, Sections 668.1-668.3, 619.17.

The requirement that the trier of fact apportion relative degrees of fault and assign percentages of liability is in accord with current standard jury instructions developed for use in the courts of this state since the adoption of comparative negligence.

5. Collateral Source

Recommendation

ELIMINATION OF THE COLLATERAL SOURCE RULE. THE COURT WOULD REDUCE ANY JUDGMENT BY AN AMOUNT EQUAL TO COLLATERAL SOURCE PAYMENTS, LESS PREMIUM PAID AND THE VALUE OF THE EMPLOYEE FRINGE BENEFIT PACKAGE. BUT IN NO EVENT MAY THE JUDGMENT BE REDUCED BY MORE THAN 50 PERCENT.

Justification

The collateral source rule prohibits the introduction into evidence of the fact that a plaintiff has already been compensated or reimbursed for

injuries from a source other than the defendant (private health insurance, workers compensation and the like). It seems improper for the plaintiff to be twice reimbursed by retaining collateral payments as well as receiving full payment for the same item from the defendant.

The proposed modification of this rule is necessary to eliminate this "double recovery" by the plaintiff. Since the underlying purpose of the tort system is to make the plaintiff whole, it is unfair for them to be twice compensated for the same item. The proper measure of the liability of the defendant should be the extent to which the plaintiff suffered uncompensated pecuniary, out-of-pocket losses.

The elimination of this rule would have a significant impact on both the amount of medical malpractice awards and insurance premiums without denying the plaintiff any uncompensated losses. A study by the American Bar Association found that in a typical state which has broadly repealed the collateral source rule, it would appear that malpractice awards would be reduced by about 20 percent. A Rand Corporation study is consistent with this finding, stating that a ban on this double recovery reduces court awards by 18 percent.

6. Structured Awards

Recommendation

A. TO STATUTORILY AUTHORIZE THE PERIODIC PAYMENTS OF CIVIL DAMAGE AWARDS. (MCR 3.104; MCLA 600.6201)

B. ALLOW EITHER PARTY TO APPLY TO THE COURT FOR A PERIODIC PAYMENT ORDER.

C. TO MANDATE THE COURT TO ENTER AN ORDER THAT DAMAGES FOR NON-ECONOMIC LOSSES IN EXCESS OF $100,000 BE PAID BY PERIODIC PAYMENTS.

D. TO REQUIRE THAT PAYMENTS OF DAMAGES FOR FUTURE LOST WAGES BE PAID IN THE YEAR IN WHICH THE WAGES WOULD HAVE BEEN PAID.

E. TO REQUIRE THAT FUTURE MEDICAL BILLS BE PAID AS THEY ARE INCURRED.

Justification

Under our current tort system, most tort judgments are paid in a lump sum payment. This practice often leads to overpayments not intended by the fact-finder. For example, an injured party is awarded compensation based on an assumption of future lost wages and medical expenses over the remainder of his/her life expectancy. If the injured party dies before that time, then the net result is a substantial payment to the heirs who are unintended beneficiaries of the tort system.

Additionally, it is these lump sum payments which some attribute as a major cause of high malpractice insurance premiums. Under current insurance practice, companies try to estimate the losses that will arise from that insurance year, but they have no way of predicting exactly when a lump sum payment will arise. Accordingly, they must create large reserve funds to assure that money is available when a large lump sum award is made. A structured settlement process will better allow the companies to adequately reserve for these large claims. Arrangements are possible under periodic payments to provide significant benefits to the victim which can be funded by an insurer at a significantly lower cost to the insurer with reasonable security to the plaintiff. For example, in a recent Michigan case an injured party who lost both kidneys due to medical malpractice received $1.2 million is guaranteed benefits (with a potential life expectancy benefits of $2.7 million) for an actual cash payout of $300,334 by the insurer.

It just makes sense to require that payments for future medical expenses be paid as they occur and for lost wages or earning capacity to be compensated in the years that they would have been earned.

The use of structured payment also helps the injured party by assuring that money will always be available for its intended purposes. It also protects the injured party from the injudicious use of lump sum settlement by

a guardian, resulting in the exhaustion of the funds before the needs of the injured party have been met. For example, in New York just two years ago, a plaintiff received a multi-million dollar settlement and today all the money has already been spent.

In conclusion, periodic payments constitute a sensible, flexible, and cost-effective method of compensating those with long-term and substantial disabilities.

7. Frivolous Actions

Recommendation

AUTHORIZE THE FULL RECOVERY OF COSTS AND REASONABLE ATTORNEY FEES INCURRED BY THE PREVAILING PARTY FROM THE OTHER PARTY, OR THEIR ATTORNEY IF THE COURT FINDS THAT A CIVIL ACTION OR DEFENSE WAS FRIVOLOUS OR SOLELY FOR HARASSMENT (SB 735 of 1984 and MCR 2.1141(E)).

Justification

Nationally, 75 percent of all medical malpractice claims are closed without payment. This would tend to indicate that a number of frivolous malpractice claims are being filed. For example, PICOM indicates that about 50 percent of all malpractice cases are dismissed without either a trial or payment of indemnity. However, even in these cases, the defendant must still pay the cost of legal defense, which amounts to thousands of dollars per case and which has risen by over 70 percent in the last three years.

While under present Michigan Court Rule, MCR 2.1141(E), there is a provision to assess reasonable expenses, including attorney fees, against a party who presents unwarranted allegations or defenses, the rule is rarely invoked. Currently there is a perception that there is little to lose by filing a frivolous lawsuit since litigation costs are rarely, if ever, awarded. There is a belief that the increase in the number of cases being filed is due to a rise in frivolous actions or defenses. Some have estimated that this runs as high as 5 to 10 percent of all civil cases. In any regard,

the number of civil actions have so clogged the court's dockets that it takes 5 years to get to trial in Wayne County, up to 3 years in other metropolitan counties, and 1 1/2 years in outstate counties.

The deterrence of frivolous or harassing legal actions will help ease the burden on the courts and help relieve the clogging of court dockets. Historically, the American legal system has never favored a general rule allowing recovery of costs to the prevailing party in a private lawsuit. Our system of jurisprudence has an unspoken public policy of encouraging free access to the courts for all citizens. Accordingly, limiting the recovery to only frivolous and harassing actions is not a great departure from past practice. It certainly does not even approach the British rule whereby the prevailing party receives reimbursement in every case. It would be an expansion of the "Equal Access to Justice" Act, Public Act 197 of 1984, which allows recovery of cost by a prevailing party from a state agency in a frivolous lawsuit.

The recommendation to statutorily authorize the payment of costs will encourage parties to oppose frivolous actions. In the past, they may have simply settled because it would cost more to litigate the case, and even if they won, they could not recover costs. This proposal will deter frivolous and harassing legal actions. The possibility of being held liable for the other party's legal expenses will cause litigants to weigh the merits of the lawsuit or the defense before filing a pleading. Since the trial judge will make the determination in awarding cost, the good-faith party has nothing to worry about. If the claim or defense has substance, it will be exhibited at trial and the judge will not tax expenses. While everyone has the right to resort to the courts to protect their legal rights, nobody has the right to abuse the court system for frivolous or harassing actions.

This type of provision would be particularly appropriate to deter and punish frivolous malpractice actions, especially if the proposed pre-trial screening panel were enacted. It could be extremely difficult in certain circumstances for a plaintiff to argue that an action was not frivolous if the panel found that the medical standard of care had not been breached. Conversely, it would be extremely difficult for a defendant to argue that a defense was not frivolous if the panel found that the standard of care had been breached.

8. Pre-Judgment Interest

Recommendation

A. TIE THE RATE OF PRE-JUDGMENT INTEREST TO THE RATE OF 5-YEAR T-BILLS. THE AMOUNT WOULD BE ADJUSTED SEMIANNUALLY.

B. ELIMINATE THE ACCRUING OF PRE-JUDGMENT INTEREST FOR THE FIRST SIX MONTHS AFTER SERVICE OF THE LAWSUIT ON THE DEFENDANT.

C. IF A REASONABLE SETTLEMENT OFFER IS MADE WITHIN THE FIRST SIX MONTHS, BUT NOT ACCEPTED UNTIL SOME TIME AFTER THE EXPIRATION OF THOSE SIX MONTHS, THEN THE PRE-JUDGMENT INTEREST WOULD START TO RUN FROM THE FIRST DAY OF THE SEVENTH MONTH. A REASONABLE SETTLEMENT OFFER IS ONE THAT IS AT LEAST 90 PERCENT OF THE AMOUNT ACTUALLY RECEIVED BY THE PLAINTIFFS BY EITHER A SETTLEMENT OR JUDGMENT. TO QUALIFY FOR THIS BENEFIT, THE DEFENDANT WOULD HAVE TO FILE A FORMAL OFFER OF SETTLEMENT WITH THE COURT.

D. IF A REASONABLE SETTLEMENT OFFER IS NOT MADE WITHIN THE FIRST SIX MONTHS AFTER SERVICE, THEN THE PRE-JUDGMENT INTEREST SHALL START TO RUN RETROACTIVELY TO THE DATE OF FILING.

Justification

Michigan currently assesses pre-judgment interest on any tort-based judgment at the rate of 12 percent per year, compounded annually from the date of filing of the complaint. The rationale behind this interest is twofold. The first is to encourage settlement by the defendant by charging interest and the second is to keep the defendant from being unjustly enriched by reaping the investment income on the amount of damages eventually owed to the plaintiff.

Historically the rate of pre-judgment interest was 6 percent. However, during the hyper-inflation of the late 70's, this rate was deemed too low. After all, if the defendant can earn interest income in double digits, as was possible at that time, why should they settle quickly for the amount of damages plus 6 percent. Accordingly, this rate was raised to 12 percent in 1980. But now that interest rates have dramatically fallen, this 12 percent rate is too high.

There is also a perception that it has become counter productive, especially when dealing with the relatively large malpractice awards, because some plaintiffs and plaintiff's attorneys are refusing to accept reasonable settlement offers so that they can continue to earn the higher 12 percent interest income. Clearly, they could not currently do as well investing an award in the financial market.

As a result, it is suggested that we reform Michigan's pre-judgment interest rate and tie it to a floating indicator so that it truly reflects the investment market. This would give both the plaintiff and defendant the same incentive to settle cases.

Additionally, there is a need in malpractice cases to encourage quick settlements of claims. As discussed in the section on Pre-Trial Screening Panels, litigation costs make up over 50 percent of the cost of malpractice insurer's expenditures. The longer it takes to resolve a case, the more it will cost. Any reform that will speed up the process of resolving these claims will result in a significant cost savings without denying the injured party any just compensation.

Therefore, this proposal, which eliminated pre-judgment interest for the first six months after filing if there is a legitimate written settlement offer by the defendant, is designed to speed up settlement of the case. But if there is no offer or no legitimate settlement offer, then the defendant

will have to pay pre-judgment interest from the date of filing. On the other hand, the plaintiff will have reduced incentive to turn down a reasonable settlement because the pre-judgment interest would not continue to run.

9. Expert Witness

Recommendation

RESTRICTIONS ON EXPERT TESTIMONY THAT SETS STANDARDS FOR QUALIFICATION OF EXPERT WITNESSES. WITH RESPECT TO AN ACTION AGAINST A NON-SPECIALIST, THERE MUST BE A REQUIREMENT THAT THE WITNESS MUST DEVOTE NOT LESS THAN 75 PERCENT OF HIS/HER PROFESSIONAL TIME TO THE ACTIVE CLINICAL PRACTICE OF MEDICINE OR TEACHING. IF THE ACTION IS AGAINST A SPECIALIST, THE WITNESS MUST ALSO BE REQUIRED TO SPECIALIZE IN THE SAME AREA OF MEDICINE AS THE DEFENDANT AND MUST DEVOTE NOT LESS THAN 75 PERCENT OF HIS/HER TIME TO ACTIVE CLINICAL PRACTICE OR TEACHING IN THE SAME SPECIALTY AS THE DEFENDANT.

Justification

This reform is necessary to regulate the use of "professional expert" witnesses in Michigan malpractice cases.

Testimony of expert witnesses is normally required to establish a cause of action for malpractice. Expert testimony is necessary to establish both the appropriate standard of care and the breach of that standard. There is currently no specific requirement for an expert witness to devote a specific percentage of time in the actual practice of medicine or teaching, or when testifying against a specialist that the expert actually practices or teaches in that specialty. Instead, a physician-witness is qualified to testify as an expert in Michigan, even though he/she does not practice in Michigan and is not of the same specialty, based on a mere showing of an acceptable background and a familiarity with the nature of the medical condition involved in the case. As a practical matter, in many courts merely a license to practice medicine is needed to become a medical expert on an issue.

This has given rise to a group of national professional witnesses who travel the country routinely testifying for plaintiffs in malpractice actions.

These "hired guns" advertise extensively in professional journals and compete fiercely with each other for the expert witness business. For many, testifying is a full-time occupation and they rarely actually engage in the practice of medicine. There is a perception that these so-called expert witnesses will testify to whatever someone pays the to testify about.

This proposal is designed to make sure that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying. In particular, with the malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists the expert witnesses actually practice in that same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns."

10. Hospital and Doctor Record Keeping

Recommendation

A. AMEND THE PENAL CODE TO MAKE IT A CRIMINAL MISDEMEANOR PUNISHABLE BY IMPRISONMENT FOR UP TO ONE YEAR AND A MAXIMUM FINE OF $5,000, OR BOTH, FOR A HEALTH CARE PROVIDER TO HAVE WILLFULLY AND WRONGFULLY CHANGED, DESTROYED, ALTERED, OR TAMPERED WITH MEDICAL RECORDS OR CHARTS.

B. AMEND THE PENAL CODE TO MAKE IT A CRIMINAL MISDEMEANOR PUNISHABLE BY IMPRISONMENT FOR UP TO ONE YEAR AND A MAXIMUM FINE OF $5,000, OR BOTH, FOR A HEALTH CARE PROVIDER TO INTENTIONALLY, WILLFULLY, OR RECKLESSLY PROVIDE MISLEADING OR INACCURATE INFORMATION TO A PATIENT REGARDING THE DIAGNOSIS, TREATMENT OR CAUSE OF A PATIENT'S CONDITION, OR TO PLACE SUCH INFORMATION IN A PATIENT'S MEDICAL RECORD OR HOSPITAL CHART.

C. REQUIRE HOSPITALS TO MAINTAIN ACCURATE AND COMPLETE PATIENT RECORDS AND DOCUMENTATION, AND TO TAKE PRECAUTIONS SO THAT SUCH RECORDS ARE NOT CHANGED, DESTROYED, ALTERED OR TAMPERED. THE FAILURE OF THE HOSPITAL TO COMPLY MAY RESULT IN A CIVIL FINE OF $5,000.

Justification

This reform is needed to prevent the concealment of a medical malpractice occurrence. The Committee is aware of a number of documented cases when medical records have been destroyed or altered, and inaccurate information has been put on charts in an attempt to hide the fact that malpractice had happened. There is a concern that this practice might be more widespread than has so far been reported.

This practice of destroying or changing records and/or telling patients inaccurate information or placing false information in medical charts is nothing more than an active cover-up of negligence. Accordingly, it should be subject to serious criminal sanctions and be the basis for license revocation.

After all, if the Legislature is going to enact measures to correct perceived inequities in the malpractice tort system, it has every right to expect the truth from the health care providers. These types of criminal sanctions are needed to punish dishonest behavior by some providers.

Finally, by acting as a significant deterrent, it will insure that injured parties will have access to accurate information about their medical treatment.

11. Peer Review and Licensing Actions

Recommendations

A. PROVIDE IMMUNITY FROM CIVIL SUITS FOR MEMBERS OF THE LICENSING BOARD.

B. PROHIBIT A COURT OR ADMINISTRATIVE AGENCY FROM STAYING A SANCTION ORDERED BY THE BOARD OF MEDICINE OR THE BOARD OF OSTEOPATHIC MEDICINE AND SURGERY.

C. CLARIFY THAT THE DETERMINATION OF SANCTIONS IS THE RESPONSIBILITY OF THE LICENSING BOARD. IF THE COURT HELD A SANCTION ILLEGAL, THEN IT MUST STATE THE REASON ON THE RECORD AND REMAND THE ACTION TO THE LICENSING BOARD FOR FURTHER ACTION.

D. EXTEND TO THREE YEARS THE TIME FRAME THAT AN INDIVIDUAL WHOSE LICENSE HAD BEEN REVOKED WOULD HAVE TO WAIT BEFORE APPLYING FOR REINSTATEMENT.

E. A LICENSEE CONVICTED FOR CRIMINAL SEXUAL CONDUCT OR A LICENSEE VIOLATING THE GOOD MORAL CHARACTER STANDARD COULD BE SUBJECTED TO BOARD IMPOSED SANCTIONS INCLUDING PROBATION, LIMITATION, DENIAL, SUSPENSION OR REVOCATION OF A LICENSE.

F. ENABLE THE LICENSING BOARD TO IMPOSE FINES AND ORDER RESTITUTION AS PART OF ITS DISCIPLINARY ACTIONS.

G. REQUIRE HOSPITALS, HMO's AND PPO's TO PROVIDE INFORMATION TO LICENSING BOARDS WHEN THEY BRING DISCIPLINARY ACTION AGAINST A PHYSICIAN RESULTING IN A CHANGE IN THEIR EMPLOYMENT STATUS OR PRIVILEGES.

H. GRANT IMMUNITY FROM CIVIL AND CRIMINAL LIABILITY TO THOSE ASSISTING A LICENSING BOARD AND FOR MAKING A REPORT TO A BOARD. THIS IMMUNITY WOULD EXTEND TO A STATE OR COUNTY HEALTH PROFESSIONAL ORGANIZATION AND TO A COMMITTEE OR OFFICER OR EMPLOYEE OF SUCH ORGANIZATION.

I. CLARIFY THAT AN INDIVIDUAL WHOSE LICENSE HAS BEEN SUSPENDED OR REVOKED COULD NOT BE ISSUED A TEMPORARY LICENSE.

J. EMPOWER THE LICENSING BOARD TO TAKE DISCIPLINARY SANCTIONS EVEN AFTER THE PERSON'S LICENSE HAS EXPIRED OR BEEN SURRENDERED.

K. AUTOMATICALLY SUSPEND OR REVOKE THE CONTROLLED SUBSTANCES LICENSE WHEN A LICENSE TO PRACTICE WAS SUSPENDED OR VOIDED.

L. MANDATE AUTOMATIC LICENSURE REVIEW SUBSEQUENT TO BOARD VERIFICATION OF THREE SUCCESSFUL MALPRACTICE CLAIMS REQUIRING TOTAL COMPENSATION IN EXCESS OF $200,000 IN ANY 10-YEAR PERIOD.

M. REQUIRE THE LICENSING BOARD TO INVESTIGATE ALLEGATIONS ON A PRIORITY BASIS.

N. MANDATE AUTOMATIC LICENSURE REVOCATION FOR A HEALTH CARE PROVIDER WHO HAS BEEN FOUND IN A JUDICIAL PROCEEDING TO HAVE WRONGFULLY CHANGED, DESTROYED, ALTERED OR TAMPERED WITH MEDICAL RECORDS OR CHARTS.

O. MANDATE AUTOMATIC LICENSURE REVOCATION FOR A HEALTH CARE PROVIDER WHO HAS BEEN FOUND IN A JUDICIAL PROCEEDING TO HAVE INTENTIONALLY, WILLFULLY, OR RECKLESSLY PROVIDES MISLEADING OR INACCURATE INFORMATION TO A PATIENT REGARDING THE DIAGNOSIS, TREATMENT OR CAUSE OF THE PATIENT'S CONDITION, OR TO PLACE SUCH FALSE INFORMATION IN A PATIENT'S MEDICAL RECORD OR HOSPITAL CHART.

P. ASSESS A SURCHARGE AGAINST THE LICENSEES TO FUND THE DISCIPLINARY ACTIVITIES AND INVESTIGATIONS IMPOSED BY THESE PROPOSALS.

Justification

Clearly, the number one cause for medical malpractice awards is negligence by the health care provider. There are "bad doctors" and there is statistical evidence that they cause a disproportionate share of the

malpractice. A study in Pennsylvania of multiple malpractice offenders indicates that 1 percent of all physicians were responsible for over 25 percent of all CAT Fund loss payments. When this is broken down by specialty, then 10 percent of all neurosurgeons account for 47 percent of all loss payments, and 4 percent of all orthopedic surgeons account for 45 percent of the losses. This figure closely correlates with a Florida study which found that multiple offenders were responsible for 24.4 percent of claim frequency against physicians.

Yet the efforts at weeding out these bad doctors through licensing actions appear to be woefully inadequate. In the entire country, only 1,381 of the nation's 430,000 doctors were disciplined last year. In 1983, there were only 1,154 doctors who had their licenses suspended or revoked, or who were subjected to other significant actions. This represents disciplinary action against only one out of every 252 doctors involved in malpractice settlements.

In addition to incompetent doctors, the American Medical Association estimates that 10,000 doctors in the United States are alcoholics and 4,000 are drug addicts. This means that at any given time 5 to 15 percent of the nation's physicians are incompetent or impaired and should not be treating patients. Despite this evidence, very few incompetent or impaired doctors are actually disciplined. For example, in 1982 of the 252 doctors nationwide who lost their licenses, in only 11 cases was it based on incompetency or malpractice.

A recent study in the Detroit Free Press indicated that Michigan's disciplinary system has been ineffective in removing the license of even "bad doctors." In 1984 Michigan took disciplinary action at the rate of only 1-8 per 1000 doctors. This ranks 38th in the country. In Michigan, in 1982-1983, only 12 MD's and 10 DO's lost their licenses, and in 1983-1984, the numbers

were 18 and 6 respectively. More astonishing is that available data indicates that no administrative complaints resulted from malpractice suits in 1984 and only three resulted from malpractice suits in 1985. Yet medical incompetence can be terribly expensive in terms of the victim and in terms of the malpractice premiums.

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

INSURANCE BUREAU
P.O. BOX 30220
LANSING, MI 48909

DEPARTMENT OF LICENSING AND REGULATION

Raymond W. Hood, Sr., Director

July 19, 1985

MEMORANDUM

TO: Interested Persons

FROM: Nancy A. Baerwaldt
Comissioner of Insurance

RE: Medical Malpractice Report

Enclosed for your information is a copy of Medical Malpractice Issues. This report details some of the concerns which have arisen regarding the current medical malpractice insurance situation in Michigan. Topics include the affordability and availability of insurance; malpractice claim filings and indemnity payments; proposed solutions and recommendations. The report also details malpractice insurance loss ratio data and premium rate schedules.

Enc.

MEDICAL MALPRACTICE ISSUES

Prepared by

Michigan Insurance Bureau
Department of Licensing and Regulation

July, 1985

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MEDICAL MALPRACTICE ISSUES

Introduction

Currently there is discussion in Michigan and nationally regarding a resurgence in the frequency and severity of medical malpractice claim filings. It is argued by trial lawyers that by the filing of malpractice claims, the quality of health care is maintained through the tort liability process; yet, it has not been proven that the threat of malpractice improves the quality of medical care by deterring substandard care.

As a result of increased claim filings, insurance companies are increasing their premiums. This increase in medical malpractice insurance premiums is being cited as prohibiting the entry of new physicians from practicing in certain specialties or causing current physicians to restrict their practice. Nationally, malpractice insurance premiums account for between 1 and 2 percent of the $350 billion health care bill. For physicians, malpractice insurance premiums average approximately 3 percent of gross income (1982) ranging from 1 percent to 2 percent for general practitioners, up to 6 percent for high risk surgical specialties. These percentages have increased only slightly since 1970.

In Michigan, a 1983 study conducted by the Office of Health and Medical Affairs shows that medical malpractice insurance is less than 7/10ths of 1 percent of the health care costs in Michigan. This undoubtedly reflects the relatively large share which hospitals represent in total health care costs.

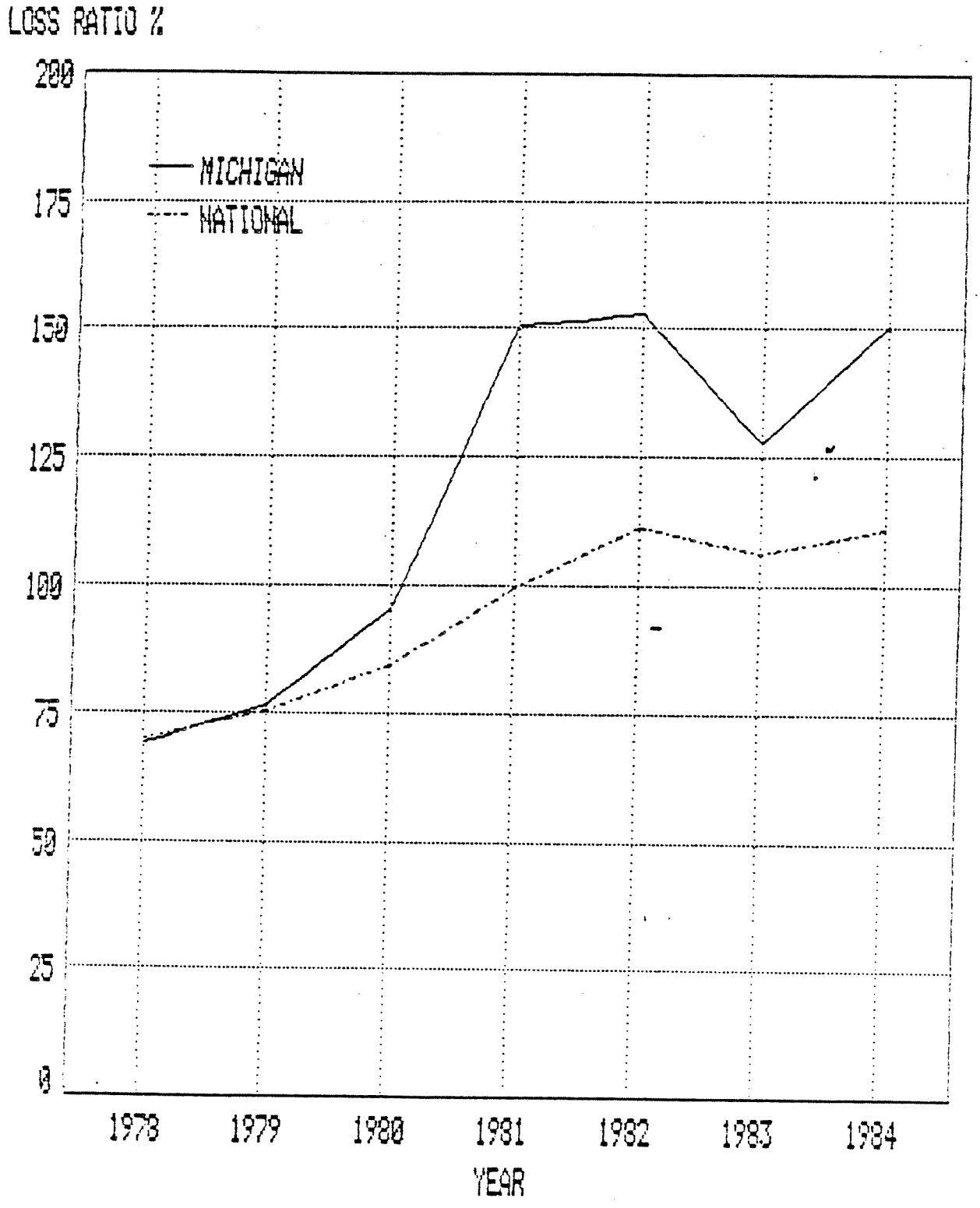
The reality is that malpractice insurance does affect the cost of health care, but there seems to be conflicting evidence as to how much this cost affects the consumer. It is clear that malpractice rates for physicians, especially those in high risk specialties, are increasing significantly. The question is will physicians change, restrict or curtail their practices and if so, how will this affect the consumer of health care? It is not clear that physicians will leave practice or work without insurance because of higher premiums. A second question is, to what extent will higher malpractice insurance premiums be passed on to consumers of health care.

There are two components to the malpractice issue in Michigan; affordability and availability. With premiums increasing between a minimum of 25 and 65 percent (with doctors of osteopathy experiencing 68 percent increases) there is legitimate concern that the cost may curtail some physicians from practicing, or cause them to change their areas of specialization.

It is clear that annual insurance company loss ratios for medical malpractice in Michigan exceed the national trend (Graph 1). Additionally, malpractice claim filings in Michigan have increased substantially over the last five years with the greatest growth in Wayne, Oakland and Macomb Counties (Graph 2). As companies increase their premiums to cover potential losses, there is concern that providers will be unable to purchase coverage.

MALPRACTICE LOSS RATIO

MICHIGAN AND NATIONAL DATA

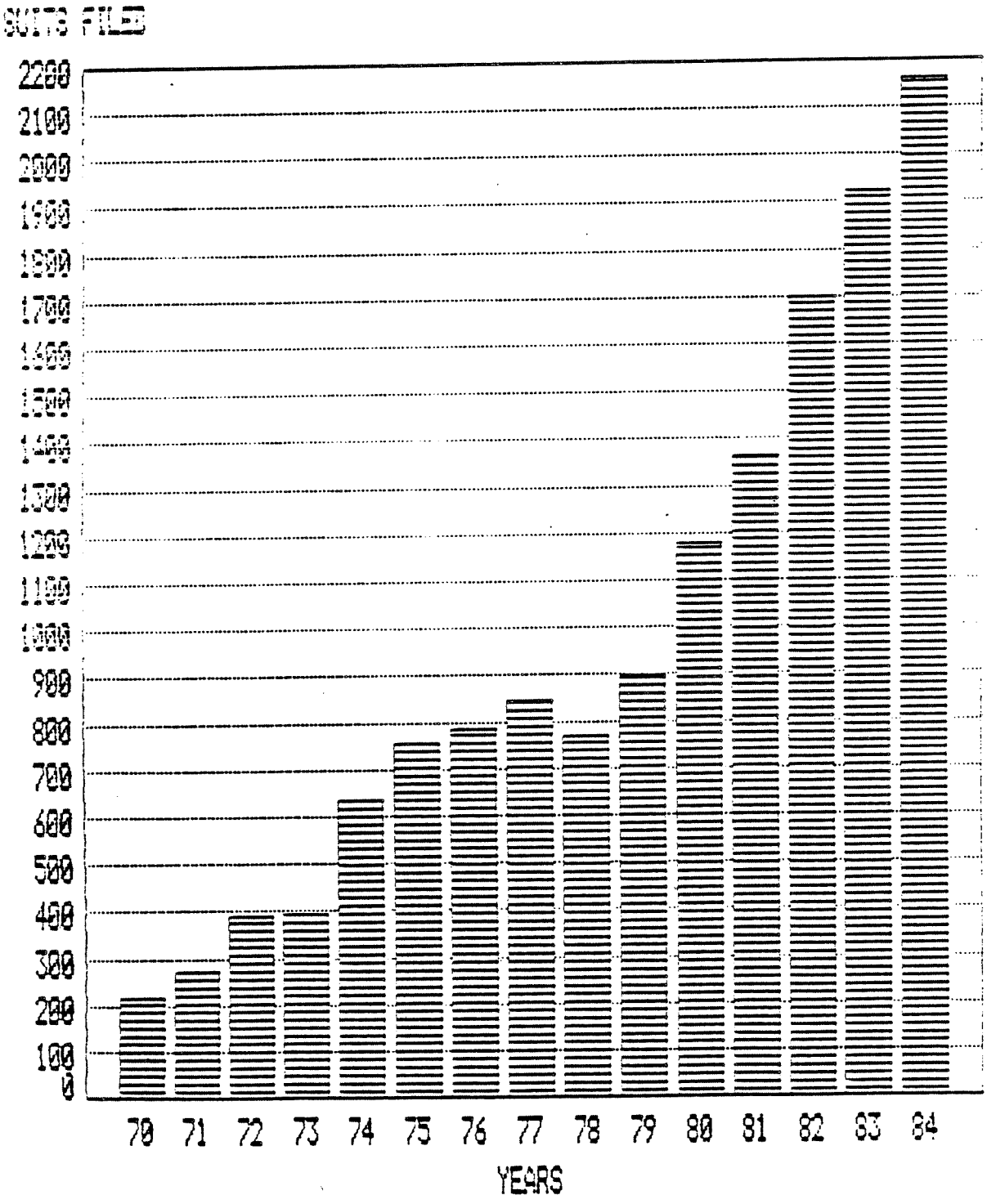


Source: Insurance Bureau and Best's Review

GRAPH 2

MEDICAL MALPRACTICE SUIT FILINGS

TRI-COUNTY AREA



Source: Physicians Insurance Company of Michigan Court Docket Survey

History

For many years medical malpractice insurance was an unremarkable product in an insurer's portfolio of coverages, just one of many types of diverse liability insurance products sold to businesses, professionals, municipalities and other entities. The first sign that this state of affairs was changing appeared in 1973 when an HEW Commissioner's Study of Malpractice reported that malpractice premiums in Michigan had increased from 85% of the national average in 1968 to 133% in 1972. Between 1973 and 1974 premiums increased an average 32%, and the following year the average increase was 96%.

At the same time, physicians in some specialties were also beginning to experience difficulty in obtaining medical malpractice insurance, particularly in the Detroit metropolitan area. By 1975, the major insurers of medical malpractice liability were refusing all new business and were retaining existing policies only under the terms of a voluntary moratorium expiring July 1. Three of the four largest writers of malpractice insurance for M.D.s subsequently withdrew from this market completely.

On January 30, 1975, Governor William Milliken requested a report on the problem from Insurance Commissioner Daniel Demlow. The report (Medical Malpractice in Michigan), which focused on Michigan's medical doctors, was issued on February 18, 1975. It identified the two basic components of the medical malpractice issue as rising premiums which ultimately translate into higher health care costs for Michigan citizens and reduced availability of insurance. After analyzing a number of measures which had been suggested by various parties for dealing with this problem, the report concluded with a series of 31 recommendations.

The recommendation with the most immediate significance was the establishment of a statutory medical malpractice insurance fund. Other recommendations concerned improved standards and enforcement efforts for physician licensing, changes in contingent fee schedules, adoption of binding arbitration, collection of additional data concerning medical malpractice, improvements in insurance rate regulation, and additional miscellaneous provisions. In response to these recommendations, the Michigan Legislature enacted a series of eighteen bills. The most significant products of these laws were the Brown-McNeely Fund, the medical malpractice arbitration program, new data reporting requirements for insurers, and new medical licensing and education requirements. Appendix A provides a more detailed listing of the 1975 malpractice legislation.

With the enactment of this omnibus package, the crisis abated. Over the next several years, the market for medical malpractice insurance improved significantly as two domestic mutual insurance companies, Michigan Hospital Association Mutual Insurance Company and Michigan Physicians Mutual Liability Insurance Company, were formed to provide this coverage in addition to the Brown-McNeely Fund. By 1980, the availability of medical malpractice insurance had improved to the point that the Brown-McNeely Fund was experiencing steady depopulation. Effective July 1, 1980, the Fund ceased writing this insurance and its book of business was assumed by another new entrant to the Michigan scene, Physicians Insurance Company of Michigan.

For the next few years, very little public attention was focused on medical malpractice insurance. However, by 1984 malpractice insurers around the nation were beginning to report adverse experience and Michigan was no exception. Once again insurers were becoming more selective in their decisions as to which doctors to insure, and after several years of fairly stable rates, malpractice insurance premiums were increasing dramatically. The problems of availability and affordability of medical malpractice insurance had returned.

I. Affordability and Availability

As indicated, rising premiums due to consistent increases in claim frequency and severity have led to questions regarding the affordability and availability of professional liability coverage. Insurance company data indicate that loss experience for physicians and surgeons continues to deteriorate, as evidenced by Graph 3 showing loss ratio data. Until the 1984 results are received and analyzed, it is not clear whether the downward trend of 1983 is the beginning of a leveling off period or an aberration. Even in 1983, however, incurred losses exceeded earned premiums for medical malpractice insurance by $25 million or 27.74 percent of the premiums.

With premium increases in 1985 between 25 and 65 percent there is legitimate concern that the cost may curtail some physicians from practicing or prohibit new physicians from practicing in certain specialties. It should also be noted that this problem is not limited to physicians. Hospitals are also facing an increase in premiums due to losses as indicated by Graph 4.

There is a growing concern that rising premiums will lead to rising health care costs. A 1978 national study showed that doctors' fees rise by 9.1 percent for every 100 percent increase in premiums when these premiums represent only 4 percent of physicians' total operating expenses. There has been no comparable study for Michigan.

TABLE 1

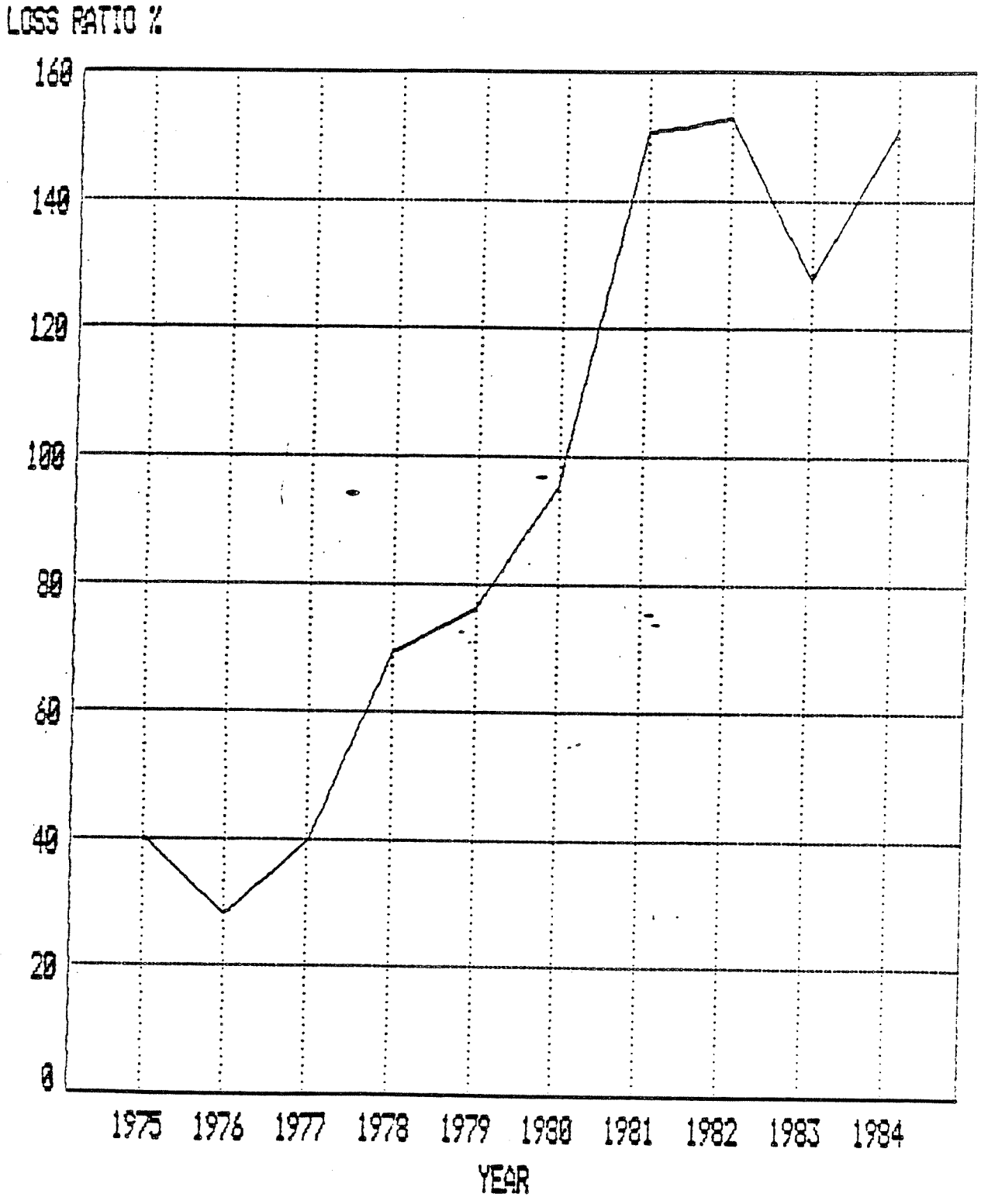
Comparison of Malpractice Insurance Premiums and Total Personal Health Expenditures in Michigan, 1977-83

Year	Premiums Earned(1) (millions)	%Change from Previous Year	%Change from 1977	Health Expenditures (millions)	%Change from Previous Year	%Change from 1977
1977	$72,055	--	--	$6,530.0	--	--
1978	69,137	-4.0%	-4.0%	7,376.0	13.0%	13.0%
1979	66,318	-4.1%	-8.0%	8,306.0	12.6%	27.2%
1980	59,916	-9.7%	-17.0%	9,449.0	13.8%	44.7%
1981	66,625	+11.2%	-8.0%	10,837.0	14.7%	66.0%
1982	89,358	+34.1%	+24.0%	11,974.0	10.5%	83.4%
1983	89,951	+.6%	+24.8%	13,000.0 (estimate)	8.6%	99.1%

1) Data include premiums earned in Michigan by all malpractice insurers, including those based outside the state.
Source: Office of Health and Medical Affairs

MEDICAL MALPRACTICE

MICHIGAN LOSS RATIO DATA



Source: Insurance companies' annual financial statements filed with the Michigan Insurance Bureau

GRAPH 4

MHAMIC LOSS RATIO

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Source: Michigan Hospital Association Mutual Insurance Company Annual Statement

In a discussion on the affordability of malpractice insurance, it is important to remember that rates in Michigan are separated into two territories. Area 1 is Wayne, Oakland and Macomb counties. Area 2 is the rest of the state.

Listed below are the current premium rate schedule and one as of 4/24/84 by class of practice and carrier: Please note that approximately 80 percent of all Michigan physicians are insured by these three companies. All coverage is on an occurrence basis with other limited sources of coverage available from other companies.

TABLE 2

RATE SCHEDULE
as of 4/24/84

Class	Medical Protective Company Area 1 - Area 2	Michigan Physicians Mutual Liability Company Area 1 - Area 2	Physicians Insurance Company of Michigan Area 1 - Area 2
II	$ 2,994 - 1,998	$ 1,850 - 1,110	$ 2,400 - 1,560
III	8,533 - 5,694	4,063 - 2,438	5,279 - 3,432
IV	12,575 - 8,392	4,979 - 2,988	9,599 - 6,239
V	18,264 - 12,188	7,384 - 4,431	11,998 - 7,799
VI	22,455 - 14,986	11,826 - 7,095	14,398 - 9,359
VII	25,449 - 16,984	12,578 - 7,548	16,798 - 10,919
VIII	28,443 - 18,982	14,504 - 8,703	19,797 - 12,868

A. Policy limits $200,000 per occurrence/$600,000 per year. The company agrees to pay up to $200,000 per incident (occurrence) with a maximum of $600,000 per year. There is no limit on defense costs.

B. Class II General practice, family practice, no surgery
Class III Minor surgery example: hysterectomy, tonsillectomy
Class IV Family practice, general practice, urology, major surgery
Class V Anesthesiology, surgery
Class VI Major surgery specialist, emergency medicine
Class VII Major surgery specialist, obstetrics/gynecology
Class VIII Surgery cardiovascular

TABLE 3

CURRENT RATE SCHEDULE*

Class	Medical Protective Company Area 1 - Area 2	Michigan Physicians Mutual Liability Company Area 1 - Area 2	Physicians Insurance Company of Michigan Area 1 - Area 2
II	$ 9,382 - 6,051	$ 5,706 - 3,766	$ 4,690 - 3,049
III	13,438 - 8,666	7,244 - 4,779	7,371 - 4,791
IV	18,813 - 12,132	13,161 - 8,685	13,401 - 8,711
V	32,250 - 20,798	16,888 - 11,146	16,751 - 10,888
VI	38,700 - 24,957	19,704 - 13,003	20,101 - 13,066
VII	45,688 - 29,464	no doctors	no doctors
VIII	48,375 - 31,197	30,198 - 19,931	23,452 - 15,244

* reflects 1985 increases

To illustrate Table 3, an obstetrician insured by MPMLC would now pay a minimum of $30,198 for insurance in Detroit compared to $19,931 in Grand Rapids, while the same physician insured by Medical Protective would pay $48,375 in Detroit compared to $31,197 in Grand Rapids.

Why are there 50 percent rate increases? Rates during the late 70's and early 80's declined at a time when claim cost and frequency were rising essentially making rates inadequate. If rates were not increased significantly in 1985 the Insurance Bureau would have required companies to do so.

Malpractice insurers have lost significant amounts of money in recent years; moreover, Section 2403 of the Insurance Code requires that rates shall not be inadequate. The Bureau is very concerned that companies which operate here remain solvent.

One of the arguments presented in the discussion of affordability is that certain specialties will experience a shortage of practitioners. Yet, the total number of physicians in Michigan has grown between the years 1963-1981.

TABLE 4

PHYSICIAN GROWTH
1963-1981

Year	Total Physicians	Ratio per Population
1963	9,580	119
1965	10,050	121
1970	10,982	125
1975	13,176	145
1980	15,347	166
1981	15,758	171

Source: Physician Characteristics and Distribution in the U.S. 1982 Edition AMA

As suggested by the above data, there are 171 physicians per 100,000 civilian population and the number of physicians grew between 1975 and 1980 -- the height of the 70's malpractice crisis in Michigan. Currently there is one physician for every 600 people in the state. Until data proves otherwise, it can be suggested that this growth in physicians would and is continuing. A listing of physicians by speciality and county is attached as Appendix A. Still, a 1982 study by the American College of Obstetricians and Gynecologists shows that 10 percent of their fellowship have stopped obstetric service because of the fear of malpractice.

Malpractice Claim Filings

A look at data received by the Insurance Bureau for 1984 shows that there were 2,787 claims filed against 133 specialties. The major categories are listed in Table 5.

TABLE 5

CLAIMS FILED BY SPECIALTY
(1984)

General Practice (minor surgery)	303
Obstetrics	263
Internal Medicine (minor surgery)	219
Orthopedic Surgery	178
Surgery (general)	116

Source: Initial Report of Court Action. This report does not include data from self-insured physicians and hospitals.

These five categories represent 41 percent of the malpractice filings for 1984. (Data for another 453 occurrences do not mention specialty.) A look at selected counties shows that claim filings in Wayne represent 46.8 percent of the filings statewide (Graph 5).

It is interesting to note that only 5 percent of all claims filed in court resulted in a formal trial while 36 percent of all claims filed in arbitration resulted in a hearing. Of these proceedings plaintiffs were successful in 27 percent of all court trials and 31 percent of all arbitration hearings.

Idemnity Payments

There is concern on the part of practitioners as to the number of substantial malpractice awards rendered by juries. For purposes of this report any award over $50,000 shall be considered substantial.

An evaluation of the Michigan medical malpractice arbitration program for the period 1976-1982 showed that 2 percent of the claims closed before filing, 12 percent of the claims filed in court, and 5 percent of the claims filed in arbitration resulted in a substantial award. Of these awards 7 percent in the court and 4 percent in arbitration resulted in payments over $100,000.

In court and arbitration the majority of payments were between $2,500 and $4,999, while claims closed before filing resulted in payments below $1,000. A breakdown of indemnity payments by procedure is in Appendix B.

Defensive Medicine

Another potential aspect of health care cost related to medical malpractice is defensive medical practice. Defensive medicine was defined before the Michigan Senate Judiciary Committee as:

> "procedures deemed by peers as unnecessary and only used to protect the physician from a lawsuit."
>
> Testimony of Dr. Louis Zako, then president of MSMS

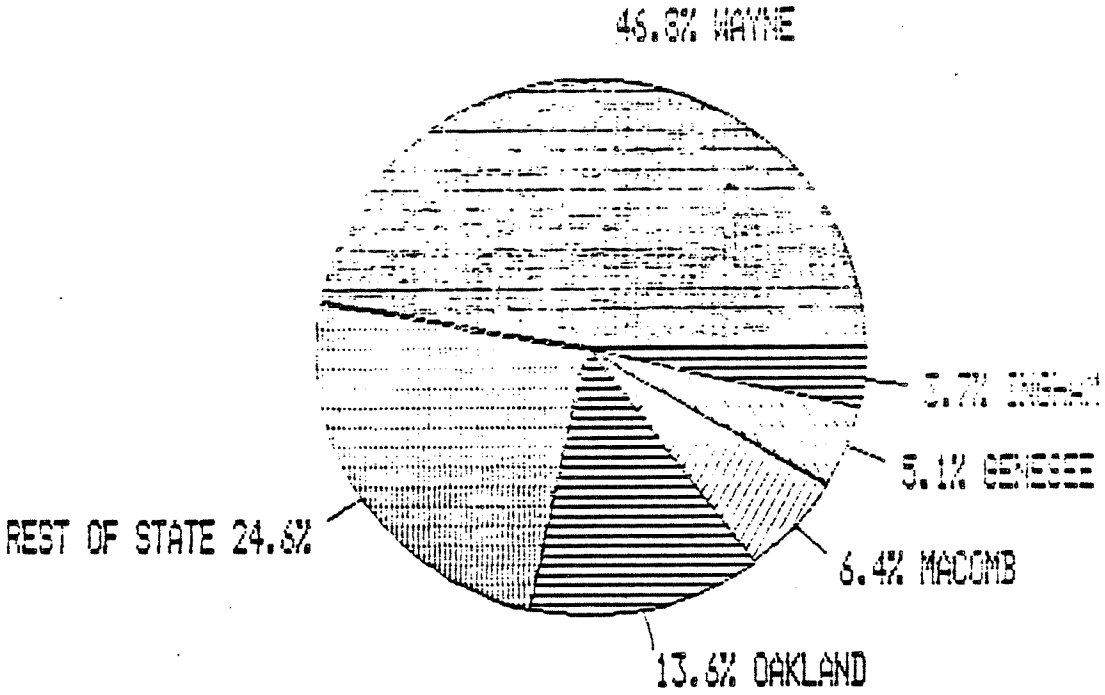
A 1978 study by Mohan L. Garg, ScD., Werner A. Gliebe, M.A., and Mounir B. Elkhatib, M.D., in the February Legal Aspects of Medical Practice stated that 8 percent of laboratory charges and 15 percent of x-ray charges were attributed to defensive medical practices. They concluded that even if 5 percent of hospital costs were for defensive medicine, the total national cost would be $2 billion per year in hospitals alone.

Findings of a 1984 study by the American Medical Association estimates that defensive medicine adds 10 percent to the total cost of medical care nationwide for an estimated $15.1 billion annually.

While no comparable study has been done in Michigan, the Office of Health and Medical Affairs believes that medical malpractice considerations are having some impact in encouraging defensive medical practice. However, the Office of Health and Medical Affairs considers defensive medicine to be beneficial from the standpoint of patients' health. From their perspective, defensive medicine is the proper practice of medicine, and as such it has no avoidable impact on health care costs.

MEDICAL MALPRACTICE CLAIM FILINGS

SELECTED COUNTIES 1984



SOURCE: MICHIGAN INSURANCE BUREAU

II. Proposed Solutions

A. Tort Reform

Physician and hospital associations have been urging changes in the tort system in order to control malpractice costs. Proposals which were introduced in the 1983-84 legislature and supported by medical providers contained the following provisions:

1. Cap on malpractice awards,
2. Modification of collateral source rule,
3. Elimination of joint and several liability and
4. Periodic payments of awards.

1. Cap on Awards

Generally a cap on non-economic damages (pain and suffering) of $500,000 is suggested. While this will eliminate the million dollar awards for non-economic losses, questions arise regarding the constitutionality of such a system. In some states where a limit or cap on recovery was instituted the laws were found unconstitutional because they were in violation of the equal protection clauses of the United States Constitution, but other states have upheld these limitations. More importantly, it is not clear whether limiting the amount of recovery would lead to stabilization of malpractice insurance premiums.

Arguments

For: A limit on non-economic recovery may lead to a significant reduction in liability payments, and thus lead to stabilization of medical malpractice insurance premiums. Controlling damages awards may reduce actuarial uncertainty, which could lower premiums and subsequent costs of health care to consumers. The California Supreme Court has upheld the constitutionality of a $250,000 limitation of non-economic damages in medical malpractice awards stating that the legislation serves the public interest by reducing malpractice costs for physicians and hospitals and assures the viability of a professional liability insurance system. Additionally, a Louisiana statute setting a $500,000 limitation on medical malpractice liability was found not to violate state or federal equal protection or due process guarantees.

Against: There is no evidence on either side as to whether savings to providers would be passed on to health care consumers in the form of lower health costs. Further, in Illinois and Ohio, limits on recovery of non-economic damages have been found to be unconstitutional. There is also concern that by denying plaintiffs the full amount of their damages, recovery and liability limits violate concepts of substantive due process. Another difficulty is that the imposition of a ceiling on recovery or liability effectively limits a common-law right without providing a "reasonable substitute."

2. Modification of Collateral Source Rule

This rule essentially states that other forms of payment which may have been or will be given to the injured party cannot be introduced in court as evidence for lowering a malpractice judgment. The reasoning is, a reduction in recovery by the amount of the collateral source would cause the deterrent impact of tort actions to be diminished or lost.

The repeal of the collateral source rule would have a measurable impact on premium costs. Some studies indicate that a relaxation of the collateral source ban would reduce trial awards by 18 percent. The aim of tort law should be to assure the plaintiff has fair compensation from available sources, not to over-compensate.

Arguments

For: There is no reason why a defendant should duplicate plaintiff's recovery. Any recovery should be for the amount necessary to compensate plaintiff for losses. The California Supreme Court recently upheld the constitutionality of a modification in the collateral source rule which makes it possible to inform a jury that the plaintiff has received compensation from a third party.

Against: Plaintiff does not purchase a health insurance policy in the hope of receiving a double recovery in case of an accident. In receiving payment from a health or accident insurer, the injured person receives exactly what they bargained for.

3. Elimination of Joint and Several Liability

Joint and several liability is based on the concept that multiple defendants are members of a group that have purposely engaged in an inappropriate action or procedure. Each defendant held in any degree of liability for an action is required to pay the entire amount of any compensation. If more than one party is sued over the same incident and a judgment is rendered, and should one party not be able to pay, then the remaining party is liable for the full amount.

Arguments

For: It is unfair to burden a defendant with the responsibility for payment of the full amount of an award in which the defendant was found to have a small percentage of liability. Further, this proposal still assures that the plaintiff is compensated for damages.

Against: In the case of a physician who has "gone bare" and is found to have the most fault, it is not clear whether the plaintiff will receive full compensation from the co-defendants or partial compensation based on degree of fault. A plaintiff could end up being under-compensated.

4. Periodic Payments of Awards

In most cases malpractice awards are given in lump sum payments with 12 percent interest compounded annually from date of filing. One reason for high malpractice insurance premiums is the practice of awarding claims on a lump sum basis. Currently companies predict the losses that will occur in the coming year in order to establish their reserves, but companies are unable to predict when a lump sum payment will occur. A structured payout allows companies to adequately reserve for a large claim. Additionally, the structured payout offers protection to the injured party by preventing injudicious use of the lump sum settlement.

Arguments

For: Recently Michigan courts began to use the structured settlement in awarding malpractice claims. Structured settlements allow for payment over the plaintiff's actual life-time or period of disability. This assures that installments will always be available for their intended purpose. Arrangements are possible under periodic payments which can be funded by an insurer with reasonable security to the plaintiff, and yet at a significantly lower cost to the insurer than an equivalent lump sum payment. Periodic payments constitute a sensible and flexible way of compensating those whose disabilities are long term and substantial.

Against: It is argued that a statute requiring periodic payments for medical malpractice awards is unconstitutional on two grounds:

a. Denial of equal protection of the law to malpractice victims because it treats them differently than other personal injury case victims.

b. The law was designed to contain medical costs by holding down malpractice rates via eliminating huge lump sum payments.

It is the denial of equal protection that most probably will be used in any constitutional challenge to this system. At this time, because the courts have instituted the system voluntarily, the Insurance Bureau is not aware of any equal protection challenges in Michigan.

An additional idea under this proposal is the elimination of the 12 percent annual pre-judgment interest. It should be noted that this interest accrues even when the case is not being tried. Michigan Hospital Association Mutual Insurance Company (MHAMIC) has indicated that, based on their files, in most cases plaintiffs' attorneys continually postpone cases. This allows for the higher interest payment upon judgment. More investigation is needed on this issue.

B. No-Fault

A relatively novel approach to compensating persons injured by medical malpractice is a no-fault concept advocated by Professor Jeffrey O'Connell. The central concept of no-fault is that the injured party would receive benefits which pay for net economic loss, medical benefits and a reimbursement for lost wages. Nothing is paid for pain and suffering. In short, the plan allows a potential tort defendant to make a preaccident commitment to make a post-accident no-fault offer that would reimburse the accident victim for net economic loss conditioned upon abandonment of any normal tort claim.

Several questions need to be asked before instituting a no-fault system for medical malpractice.

1. Will this system adequately compensate injured persons? This would depend on the level of benefits to be provided.

2. Would this system save money? Some study is needed to determine whether paying more but smaller claims would be no more expensive than paying fewer but more costly claims through the tort system. Alternatively, would there be sufficient savings in expense costs to offset paying a larger number of relatively small claims?

3. Would this system improve predictability, so that insurers could better price this insurance? Improvements in predictability of claim costs would make insurers more willing to write this coverage and would stabilize rates.

Nonetheless, a no-fault approach is an intriguing idea that has worked well in other liability situations such as automobile and workers' compensation insurance, and it is definitely worth looking into further.

C. Limitation on Attorney Fees

California has also recently upheld a sliding scale of contingent fees for attorneys handling medical malpractice cases, a system which Michigan had adopted but recently abandoned.

A study by Professor Jeffrey O'Connell shows that 73 cents out of every dollar recovered by a malpractice plaintiff goes to the attorney. The recently upheld California statute requires that fees diminish as the size of the award increases and consequently, the maximum an attorney could receive on a million dollar award is 15 percent. Trial lawyers argued that the contingent fee was necessary to provide access to the courthouse and to underwrite their own costs of doing business.

The court ruled that the limits do not prevent malpractice victims from obtaining qualified legal representation and that the fee limits serve their intended purpose of discouraging attorneys from filing frivolous or marginal malpractice suits.

D. Claims Made Policies

There is strong pressure nationally on all insurers to begin to sell claims-made policies for all types of liability insurance within the next five years. Michigan currently does not allow this type of policy for medical malpractice insurance and, a reevaluation of this position may be needed. However, claims-made policies do not do anything to control the cost of medical malpractice insurance in the long run. There would be short-term savings because in the first year, policies would only cover the claims which occurred and were reported in that year. Claims-made policies are supposed to have the advantage of allowing insurers to price this coverage more accurately. On the other hand, claims-made policies are more likely to give rise to breaks in coverage if the physician or agent is not extremely careful, and it is difficult to change insurers under a claims-made system.

E. Requirement of Financial Responsibility

As a requirement for licensure it is proposed that health care providers be required to file proof of financial responsibility with the Commissioner of Insurance; moreover, this proof may be an insurance policy or bond in an amount that will cover a specified liability limit. The requirement of liability helps ensure that physicians will take responsibility for their actions and does not allow them to hide assets. This also helps to alleviate the liability that may be faced by hospitals and other insured institutions in the event a compensable event occurs and the physician fails to have coverage.

F. Patient Compensation Fund

The purpose of this fund would be to pay the amount due from a judgment or settlement that is above the total liability carried by a provider. This fund may help stabilize medical malpractice premiums by controlling the amount of damage awards. Funding would be through a surcharge on providers not to exceed 10 percent of the cost to the health care provider of maintaining financial responsibility.

The main argument against this proposal is the fact that it generally means establishing a limit on the amount a plaintiff can recover in a successful malpractice action. There is also concern that a fund does not provide any incentive to health care providers to modify procedures or actions which lead to a malpractice action.

It should be noted that in states where this option has been tried problems have occurred. For example, in Hawaii a 1981 audit showed that the fund had failed to provide for $5.5 million in recorded losses; and in Florida the fund collapsed after hospitals and physicians began withdrawing during the early 80's in response to rate increases and retroactive assessments. Seventy-eight Florida hospitals are now being assessed to pay claims which arose while the fund was still operative.

G. Reinstituting Brown-McNeely Fund

The purpose of the Brown-McNeely Fund was to provide eligible providers with insurance coverage until the insurance industry could offer coverage at reasonable rates. By the end of the 1970's, the crisis which led to the formation of the Fund had apparently subsided and in the early 80's Brown-McNeely became Physicians Insurance Company of Michigan.

With the availability of coverage once again a key question it may be necessary to reinstitute Brown-McNeely by repealing Section 2517 of the Insurance Code which states that the Fund shall not issue or renew a policy beyond July 1, 1980. Additionally, a servicing insurer would need to be found.

H. Malpractice Arbitration Program

Michigan's malpractice arbitration system was instituted for the following reasons:

1. To reduce costs.
2. To promote equitable settlements.
3. To expedite the resolution of claims.
4. To provide patients with a freedom of choice by instituting arbitration as an alternative to litigation.

The arbitration plan viewed the patient compensation process as a continiuum which begins with a medical maloccurrence, continues through institutionalized attempts to conciliate and resolve the dispute at the health care delivery level and culminates in a final and binding arbitration. The focus of Michigan's plan was the fact that every meritorious claim is fundamentally a health problem to be resolved in part by the award or remedial services, wherever possible, and in part by dollar compensation, wherever appropriate.

An analysis of the arbitration process shows that from filing to closing statewide takes 20 months in arbitration as compared to 23 in court. For the tri-county area the comparable figures are 20 months and 24 months respectively. On this point, the Bureau's evaluation shows that of claims closed between 1976 and 1982 only 5 percent of all claims filed in court resulted in a formal trial while 36 percent resulted in an arbitration hearing. Of these proceedings, plaintiffs were successful in 27 percent of all court trials and 31 percent of all arbitration hearings.

There are no grounds to believe there exists an actual bias in arbitration. There is evidence to indicate award sizes overall as well as for similar injuries are lower in arbitration than the court system. Plaintiff's counsel's perception of smaller awards may explain their opposition to arbitration. Plaintiffs' counsel believe arbitration produces smaller awards; when they have a claim which warrants a major award they seek to have the dispute resolved in the court system. The result is a reduction in the number of cases handled by arbitration that potentially involve substantial awards. Yet, our study shows that only 7 percent of the cases filed in court result in an award over $100,000 as compared to 4 percent in arbitration, a statistically insignificant difference.

There was a constitutional cloud surrounding arbitration and the total number of closed claims are relatively limited but for those claims which have closed during the study period, arbitration provided a faster, less costly and more consistent method of resolving medical malpractice disputes than the courts.

The arbitration program can be opposed or supported on a variety of grounds. Arbitration is a less expensive method for resolving medical malpractice disputes -- $240 lower loss adjustment expense. If arbitration agreements were not routinely challenged as invalid, the cost savings might be even greater (estimated additional savings of at least $500 per claim). The combination of lower loss adjustment expense generally and savings in legal expenses related to challenges might generate $700 to $800 in savings per claim.

Current evidence from the arbitration program shows that its desired outcomes have been achieved yet there is not enough evidence to prove that this system should be expanded by making it mandatory for all malpractice disputes.

III. Recommendation

The issue of medical malpractice is a very complex and important one not only to Michigan but nationally. Various news reports have appeared discussing the issue and proposed solutions.

The department is deeply concerned because the licensed medical professionals and insurance community are under our jurisdictional roof. Therefore, it is our recommendation that the Governor appoint a blue ribbon task force with members to include the legislature, affected medical and insurance communities and the public. The purpose of this task force would be;

-- to examine and identify issues and information relating to medical malpractice in Michigan.

-- to develop policy recommendations addressing the legal, disciplinary, regulatory, financial and marketplace considerations necessary to assure a cost-effective, fair and reasonable medical malpractice system in Michigan.

APPENDIX

Availability

Public Act	Description of Act	MCLA cite
P.A. 43 of 1975	Creation of the Brown-McNeely Fund, a state fund to provide insurance for doctors who can not obtain coverage through private companies.	MCLA 500.250
Cost		
P.A. 44 of 1975	The Insurance Code was amended to require insurers to report to the Bureau: (1) Claims Action, (2) Settlement Amount, (3) Final Dispositions of cases brought against insured physicians, podiatrists, dentists and hospitals.	MCLA 500.2477
P.A. 106 of 1975	State Professional Societies report Disciplinary Action Taken Against Members to Osteopaths Licensing Board.	MCLA 338.109a
P.A. 107 of 1975	State Professional Societies report Disciplinary Action Taken Against Members to Physicians Licensing Board.	MCLA 338.1811a
P.A. 111 of 1975	Removal or suspension from hospitals of licensed doctors reported to medical licensing board.	MCLA 331.422
P.A. 112 of 1975	Fifty hours continuing education requirement for license renewal for doctors, podiatrists and osteopaths.	MCLA 338.1810 MCLA 338.304(1) MCLA 338.103(2)
P.A. 119 of 1975	Immunity from lawsuits for peer review committees, to encourage doctors to police their own ranks for those giving inadequate care.	MCLA 331.531
P.A. 125 of 1975	Regulation giving those involved in a malpractice suit more direct access to medical records while prohibiting the sale of any of the information without the patient's consent.	MCLA 750.410

Public Act	Description of Act	MCLA cite
P.A. 140 of 1975 P.A. 141 of 1975	Establishment of statewide system of voluntary, contractual and binding arbitration of medical malpractice disputes.	MCLA 600.101 MCLA 500.100
P.A. 142 of 1975	Modification of the statute of limitations for medical malpractice injury suits to two years after treatment, except when the patient can prove he or she could not have known of the injury until after two years.	MCLA 600.5838
P.A. 143 of 1975	Subpoena power granted to Licensure Boards for doctors.	MCLA 338.1805
P.A. 144 of 1975	Subpoena power granted to Licensure Boards for podiatrists.	MCLA 338.301
P.A. 174 of 1975	Subpoena power granted to Licensure Boards for osteopaths.	MCLA 338.102
P.A. 198 of 1976	Medical Practices Board Membership expanded to include three public members. Basis for authorized investigations expanded to include complaint, or motion by members of Board, Board may solicit patient testimony if reasonably relevant to existing complaint. Board provides complaint forms by which the public or other licensees may file written complaints.	MCLA 338.1805
P.A. 307 of 1976	Insurance Bureau must examine reserving practices of malpractice carriers and include investment income in rate approval process.	MCLA 500.810

APPENDIX B

GENERAL PRACTICE	
GP	General Practice*
FP	Family Practice
MEDICAL SPECIALTIES	
A	Allergy
CD	Cardiovascular Diseases
D	Dermatology
GE	Gastroenterology
IM	Internal Medicine
PD	Pediatrics
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
PUD	Pulmonary Diseases
SURGICAL SPECIALTIES	
GS	General Surgery
NS	Neurological Surgery
OBG	Obstetrics and Gynecology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OTO	Otorhinolaryngology
PS	Plastic Surgery
CRS	Colon and Rectal Surgery
TS	Thoracic Surgery
U	Urology
OTHER SPECIALTIES	
AM	Aerospace Medicine
AN	Anesthesiology
CHP	Child Psychiatry
DR	Diagnostic Radiology
FOP	Forensic Pathology
N	Neurology
OM	Occupational Medicine
P	Psychiatry
PTH	Pathology
PM	Physical Medicine and Rehabilitation
GPM	General Preventive Medicine
PH	Public Health
R	Radiology
TR	Therapeutic Radiology
OS	Other Specialty
US	Unspecified

*Includes Family Practice and General Practice in Detail Tables 2-14.

Source: Physician Characteristics and Distribution in the U.S. 1982 Edition, American Medical Association

MICHIGAN

SPECIALTY	Total Physicians	MAJOR PROFESSIONAL ACTIVITY: PATIENT CARE: Total	PATIENT CARE: Office Based Practice	PATIENT CARE: HOSPITAL BASED PRACTICE: Residents-All Years	PATIENT CARE: HOSPITAL BASED PRACTICE: Full-Time Physician Staff	OTHER PROFESSIONAL ACTIVITY: Medical Teaching	OTHER PROFESSIONAL ACTIVITY: Administration	OTHER PROFESSIONAL ACTIVITY: Research	OTHER PROFESSIONAL ACTIVITY: Other
TOTAL PHYSICIANS	15,758	13,175	9,643	2,528	1,004	208	388	484	93
GENERAL PRACTICE	1,758	1,705	1,434	198	73	20	25	3	3
MEDICAL SPEC.	4,436	3,837	2,877	777	283	83	84	320	12
A	59	57	57					2	
CD	296	239	217		22	7	8	41	3
D	221	217	174	37	6	2		2	
GE	122	97	89		8	1	1	22	1
IM	2,651	2,375	1,650	587	138	42	45	182	7
PD	945	854	620	171	63	27	28	35	1
PDA	12	11	9	2				1	
PDC	19	13	7		6	1	1	4	
PUD	111	74	54		20	3	3	31	
SURGICAL SPEC.	4,012	3,577	2,588	750	141	42	35	45	13
GS	1,317	1,265	865	349	52	15	15	16	5
NS	111	104	79	19	6	1		5	1
OBG	1,057	1,025	809	185	31	10	12	8	2
OPH	411	400	348	43	9	4	1	5	1
ORS	449	442	335	88	19	2	1	1	3
OTO	184	174	146	22	6	5	3	2	
PS	105	101	85	10	6	1		3	
CRS	40	39	38	1	2			1	
TS	76	72	65	4	2		3		1
U	282	234	217	29	8	4		4	
OTHER SPEC.	4,144	3,656	2,348	803	507	83	244	116	65
AM	2	1		1			1		
AN	455	436	358	43	37	9	3	6	1
CHP	125	100	55	13	32	7	15	4	
DR	303	288	186	67	35	5	1	4	5
FOP	10	5	4		1		1	1	3
N	158	138	113	18	7	2	1	14	1
OM	142	111	107	3	1	1	29		1
P	902	818	544	107	165	19	50	13	4
PTH	480	378	233	54	91	6	30	19	27
PM	91	88	61	14	11	3	2		
GPM	23	14	10	4			8	1	
PH	59	11	6	4	1	1	38	5	4
R	335	288	301	19	48	2	4	11	10
TR	50	48	39	1	8			2	
OTHER	421	310	251		59	8	58	28	9
UNSPECIFIED	549	546	80	455	11		3		
NOT CLASSIFIED	437								
INACTIVE	873								

Source: Physician Characteristics and Distribution in the U.S. 1982 Edition

STATE COUNTY	TOTAL NON-FEDERAL PHYSICIANS	MAJOR PROFESSIONAL ACTIVITY-December 31, 1981								
		PATIENT CARE						Other Professional Activity	Inactive	Not Classified
		TOTAL	OFFICE BASED PRACTICE				Hospital Based Practice			
			General Practice	Medical Specialties	Surgical Specialties	Other Specialties				
NORFOLK	2,243	1,750	89	393	346	351	571	276	138	78
PLYMOUTH	491	412	43	119	111	85	74	14	55	10
SUFFOLK	4,822	3,225	88	541	462	454	1,880	1,243	114	240
WORCESTER	1,522	1,235	108	295	240	177	415	151	88	46
MICHIGAN										
MICHIGAN	15,758	13,175	1,434	2,577	2,988	2,346	3,532	1,173	973	437
ALCONA	7	2	2						5	
ALGER	3	3	2		1					
ALLEGAN	40	34	17	2	8	6	1	1	5	
ALPENA	40	35	10	5	12		8		4	1
ANTRIM	9	5	3			2			4	
ARENAC	6	6	1	3	2					
BARAGA	7	5	3		1		2		1	
BARRY	31	24	11	1	6	4	2	2	3	2
BAY	111	95	8	22	31	31	3	2	13	1
BENZIE	14	10	3	2	1	3	1		4	
BERRIEN	206	178	36	39	55	40	8	1	22	
BRANCH	33	27	5	6	9	3	3		5	
CALHOUN	167	140	28	26	43	31	12	8	17	2
CASS	15	11	5	2	3	1		1	3	
CHARLEVOIX	21	14	6	4	3	1			6	1
CHEBOYGAN	13	9	1	2	2	3	1	1	3	
CHIPPEWA	28	20	8	5	3	3	1		7	1
CLARE	4	2	1		1				2	
CLINTON	20	17	6	1	1	4	5	1	1	1
CRAWFORD	10	8	3	2	3	1			1	
DELTA	40	37	15	5	11	4	2		3	
DICKINSON	37	30	11	5	7	6	1		5	2
EATON	27	18	10	4	1	2	1	4	5	
EMMET	83	79	3	25	28	22	1	4	7	3
GENESEE	687	600	87	112	118	106	177	28	29	30
GLADWIN	6	6	3	1	1	1				
GOGEBIC	18	12	7	1	3	1			3	1
GRAND TRAVERSE	141	121	10	28	32	29	22	7	11	2
GRATIOT	39	33	9	7	9	8	2	1	5	
HILLSDALE	20	16	6	4	5		1		4	
HOUGHTON	38	31	6	6	9	5	2	1	6	
HURON	33	31	7	9	10	2	3		2	
INGHAM	648	506	67	122	98	87	132	91	38	13
IONIA	22	21	10	6	4		1	1		
IOSCO	23	22	8	4	5	2	3		1	
IRON	9	7	3	1	2		1		1	1
ISABELLA	42	40	6	13	14	3	4		2	

*Non federal physicians refers to those physicians not attached to the armed services or working in a veteran's facility

Source: Physician Characteristics and Distribution in the U.S. 1982 Edition

STATE COUNTY	TOTAL NON-FEDERAL PHYSICIANS	MAJOR PROFESSIONAL ACTIVITY-December 31, 1981								
		PATIENT CARE						Other Professional Activity	Inactive	Not Classified
		TOTAL	OFFICE BASED PRACTICE				Hospital Based Practice			
			General Practice	Medical Specialties	Surgical Specialties	Other Specialties				
JACKSON	143	124	25	33	38	21	7	3	15	1
KALAMAZOO	540	444	50	117	109	82	86	52	37	7
KALKASKA	3	3	3							
KENT	897	798	47	171	222	128	228	28	63	10
KEWEENAW	1								1	
LAKE	7	5	2	1		2			2	
LAPEER	29	24	6		4	5	9	1	4	
LEELANAU	9	5	1	1	1	1	1		4	
LENAWEE	78	66	14	16	17	16	3		7	3
LIVINGSTON	55	43	6	6	9	10	10	3	8	1
LUCE	15	10	4			1	5	3	2	
MACKINAC	5	1	1						4	
MACOMB	609	537	54	161	153	75	94	27	25	10
MANISTEE	23	16	3	4	5	1	3	1	6	
MARQUETTE	122	108	16	26	32	18	16	5	7	2
MASON	37	32	12	4	9	4	3		5	
MECOSTA	19	15	4	3	4	4			3	1
MENOMINEE	11	8	3	1	2	1	1		2	
MIDLAND	123	108	23	13	26	21	25	9	5	
MISSAUKEE	4	2	1	1					2	
MONROE	71	57	16	17	14	6	4	3	8	2
MONTCALM	27	22	11	4	4	2	1	1	3	2
MONTMORENCY	3	1	1					1	1	
MUSKEGON	179	153	23	42	40	33	9	5	18	
NEWAYGO	18	15	11		1	2	1	1	2	
OAKLAND	3,241	2,803	134	693	652	557	787	187	178	3
OCEANA	12	10	6		2	2		1	1	
OGEMAW	12	10	3	2	3	2		1	1	
ONTONAGON	6	6	6							
OSCEOLA	6	5	5						1	
OSCODA	4	2	2						2	
OTSEGO	18	15	3	3	3	5	1	1	1	1
OTTAWA	150	125	21	20	46	29	7	4	18	5
PRESQUE ISLE	5	5	2		1	1	1			
ROSCOMMON	9	5	3	1		1			4	
SAGINAW	301	254	58	43	64	51	40	17	20	10
ST CLAIR	131	113	16	27	45	20	5	3	11	6
ST JOSEPH	43	38	17	5	5	6	3		5	2
SANILAC	17	13	9	1	3				3	1
SCHOOLCRAFT	7	6	4			1	1		1	
SHIAWASSEE	48	45	11	11	15	5	3	2	2	
TUSCOLA	22	20	8	5	5	1	1		2	
VAN BUREN	48	35	17	1	4	8	5	2	10	2
WASHTENAW	1,509	1,383	53	245	198	294	593	331	51	44
WAYNE	4,104	3,408	279	717	696	520	1,196	344	201	151
WEXFORD	31	24	5	5	10	1	3	3	2	2

Source: Physician Characteristics and Distribution in the U.S. 1982 Edition

APPENDIX C

Indemnity Payments by Procedure

For Claims Closed Before Filing

	None	1-999	1,000-2,499	2,500-4,999	5,000-9,999	10,000-24,999	25,000-49,999	56,000-99,999	100,000+	#
Nervous	67%	17	0	0	17	0	0	0.	0	(6)
Eye, Ear, Nose, Throat	55%	14	14	8	6	3	0	1	0	(72)
Respiratory System	53%	0	6	0	6	0	12	12	12	(17)
Cardio-vascular	73%	14	11	3	0	0	0	0	0	(37)
Digestive System	41%	24	5	5	12	7	0	1	5	(76)
Genitourinary	50%	10	6	5	9	15	4	1	0	(144)
Obstetrical	72%	3	6	6	4	10	0	0	0	(71)
Musculo-skeletal	50%	22	6	7	7	7	0	0	0	(54)
Integumentary	35%	15	30	15	0	0	0	5	0	(20)
Diagnostic Radiology and Nuclear Medicine	65%	15	13	0	6	1	0	0	0	(79)
Examinations, Evaluations	46%	21	17	17	0	0	0	0	0	(24)
Physical Therapy and Rehab.	47%	23	17	0	3	10	0	0	0	(30)
Non-Operative Procedures	53%	13	23	0	10	0	0	0	0	(30)
Intravenous	37%	23	12	9	9	3	5	3	0	(78)
Miscellaneous	57%	11	7	11	8	3	1	.5	2	(391)
TOTAL	54%	14%	9%	7%	7%	5%	1%	1%	1%	
(#)	610	155	105	84	83	55	15	10	12	(1129)

Source: Evaluation State of Michigan Medical Malpractice Arbitration Program, Technical Report Volume I, October 1983

Indemnity Payments by Procedure

For Claims Filed With Court System

	None	1-999	1,000-2,499	2,500-4,999	5,000-9,999	10,000-24,999	25,000-49,999	56,000-99,999	100,000+	#
Nervous	56%	0	0	13	0	19	6	0	6	(16)
Eye, Ear, Nose, Throat	60%	3	10	9	8	3	0	1	8	(79)
Respiratory System	47%	7	7	13	7	7	7	7	0	(15)
Cardio-vascular	34%	4	2	2	10	16	2	14	16	(50)
Digestive System	43%	1	9	7	11	8	4	8	9	(107)
Genitourinary	44%	4	14	13	7	7	6	3	5	(155)
Obstetrical	50%	2	3	4	10	9	9	6	7	(90)
Musculo-skeletal	45%	2	9	16	5	8	5	10	1	(114)
Integumentary	42%	2	2	7	22	7	0	2	16	(45)
Diagnostic Radiology and Nuclear Medicine	42%	7	18	4	10	1	6	4	9	(82)
Examinations, Evaluations	35%	0	8	14	11	5	11	11	5	(37)
Physical Therapy and Rehab.	59%	0	0	12	12	0	18	0	0	(17)
Non-Operative Procedures	23%	0	15	15	8	12	8	8	12	(26)
Intravenous	31%	0	16	16	7	18	2	2	7	(55)
Miscellaneous	35%	3	9	13	11	11	6	4	7	(420)
TOTAL	41%	3%	10%	11%	10%	9%	6%	5%	7%	
(#)	535	36	125	143	126	114	72	66	91	(1308)

Source: Evaluation State of Michigan Medical Malpractice Arbitration Program Technical Report Volume I, October 1983

Indemnity Payments by Procedure

For Claims Filed With Arbitration

	None	1-999	1,000-2,499	2,500-4,999	5,000-9,999	10,000-24,999	25,000-49,999	56,000-99,999	100,000+	#
Nervous	0%	0	25	0	0	25	0	0	50	(4)
Eye, Ear, Nose, Throat	43%	14	29	0	0	0	0	14	0	(7)
Respiratory System	0%	0	0	100	0	0	0	0	0	(1)
Cardio-vascular	0%	0	0	100	0	0	0	0	0	(2)
Digestive System	75%	0	0	0	0	0	0	0	25	(4)
Genitourinary	53%	7	0	20	7	13	0	0	0	(15)
Obstetrical	0%	0	0	0	100	0	0	0	0	(1)
Musculo-skeletal	54%	15	8	0	8	15	0	0	0	(13)
Integument.	100%	0	0	0	0	0	0	0	0	(1)
Diagnostic Radiology and Nuclear Medicine	67%	0	0	0	17	17	0	0	0	(6)
Examinations, Evaluations	-	-	-	-	-	-	-	-	-	(0)
Physical Therapy and Rehab.	0%	33	0	0	33	33	0	0	0	(3)
Non-Operative Procedures	40%	0	40	20	0	0	0	0	0	(5)
Intravenous	29%	0	14	29	0	29	0	0	0	(7)
Miscellaneous	28%	7	17	21	17	7	0	0	3	(29)
TOTAL	#39%	7%	12%	15%	10%	11%	0%	1%	4%	
(#)	38	7	12	15	10	11	0	1%	4%	(98)

Source: Evaluation State of Michigan Medical Malpractice Arbitration Program, Technical Report Volume I, October 1983

APPENDIX D

Note on Hospital Liability Coverage

It has recently been brought to the Insurance Bureau's attention that Argonaut Insurance Company, which at one time insured thirty-three hospitals in the state, will not issue or renew liability policies after July 1, 1985. Policies with a July 1 renewal date will not be honored. Nationally Argonaut has decided to withdraw from the hospital liability market. The decision to abandon hospital coverage was made after the company switched from occurrence to claims-made policies last year and they found that their experience continued to deteriorate. Argonaut stated that the excessive reserving the company had to do for the incurred but not reported claims and the long tail on medical malpractice reporting led to the decision to leave the hospital liability market.

Some of the hospitals previously insured by Argonaut will find coverage through Michigan Hospital Association Mutual Insurance Company, while others will turn to nonlicensed excess insurance companies.

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF MANAGEMENT AND BUDGET

P.O. BOX 30026, LANSING, MICHIGAN 48909

ROBERT H. NAFTALY, Director

Office of Health and Medical Affairs

Telephone 517/373-8155/373-9650

MEMORANDUM

DATE: January 15, 1986

TO: Statewide Health Coordinating Council and Interested Parties

FROM: OHMA Staff

SUBJECT: PROPOSED POSITION ON MEDICAL MALPRACTICE ISSUES (based on the issues described in the staff memo of January 8, 1986)

1. SUPPORT the House and Senate recommendations on peer review and licensing, strengthening sanctions against willfull and wrongful alterations to medical records, and providing for civil immunity for members of licensing boards as consistent with previous SHCC positions on reform of the system for regulating and disciplining health care professionals.

2. SUPPORT the creation of a state administered Medical Liability Fund for the purpose of assuring the availability of medical malpractice insurance for those who cannot obtain coverage in the private market.

3. SUPPORT a two-phased approach for handling the remainder of the issues as follows:

   a. Do not institute pre-trial screening panels until other methods of dispute resolution can be examined including Michigan's arbitration system.

   b. Do not establish an absolute statute of limitations on the right to bring action as such limitations impose severe hardship in cases where the evidence of malpractice does not become apparent until several years after the incident.

   c. Do not establish a cap on non-economic damages because such caps impose potentially severe burdens on persons who are rendered handicapped as a result of malpractice and must sustain ongoing expenditures of a non-medical nature in order to maintaion an independent lifestyle.

d. Establish changes in the laws governing joint and several liability.

e. Create statutory disincentives for filing frivolous claims or maintaining frivolous defenses.

f. Oppose new restrictions on the qualification of expert witnesses.

g. Tie rating schedules for liability insurance to risk management efforts.

I S P R

Institute for the Study of Professional Risk

P.O. Box 3234 • Ann Arbor, MI 48106 • 313/668-1567

ANALYSIS OF DR. ROBBEN FLEMING'S REPORT ON HEALTH CARE PROVIDER MALPRACTICE AND MALPRACTICE INSURANCE"

SUMMARY

The report of Dr. Fleming is a scholarly and insightful evaluation of the nature of the current professional liability "crisis". It provides a basis for long-term solutions to the medical malpractice liability question, as well as for a short-term compromise to the perceived insurance "crisis". The specific findings concerning the nature and incidence of malpractice and the nature, number, disposition and costs of malpractice claims, are based upon information which support the generally excellent, long-term recommendations.

Careful review and analysis by the Institute for the Study of Professional Risk supports the following conclusions:

-- Malpractice and malpractice claims will be reduced significantly if the proficiency of otherwise competent, but error-prone health care providers, is improved.

-- Most current risk management is simply claims management. There has been little effort made at true loss prevention, i.e. identifying existing and potential sources for malpractice.

-- Only through active efforts at loss prevention will incidence of medical malpractice be reduced.

-- Insurers should be required to invest resources in loss prevention.

-- If health care providers are not legally required to be insured, individual loss prevention programs should be required as a condition of licensure.

-- The State must have a disciplinary and regulatory system which requires maintenance of high standards of medical performance as well as competence.

-- Medical schools should be involved in the local and state medical disciplinary and regulatory process.

-- An "excess" and "long tail" liability fund should be created but must be accompanied by several measures to ensure success.

-- Alternative dispute resolution mechanisms should be explored, but must have the wholehearted support of users of the system.

LONG-TERM RECOMMENDATIONS

The two primary goals of our system of medical malpractice liability should be to (1) reduce the incidence of medical malpractice as much as possible, and (2) to compensate victims of medical malpractice.

Incidence Reduction

Efforts toward reduction of the incidence must begin with defining the nature and incidence of malpractice. As Dr. Fleming's report indicates, medical malpractice is a much larger problem than is reflected in the number of malpractice claims, high as they are. His investigation discloses important information about the sources of incidents which lead to claims.

His finding that "a disproportionate number of malpractice claims are filed against a relatively small number of providers who, though they are not generally considered to be incompetent, appear to be susceptible, for various reasons to the commission of errors", is extremely important. The data accompanying this finding supports the experience and perception of both physicians and attorneys who are knowledgeable in the area of medical malpractice liability.

Although both incompetent physicians and frivolous lawsuits are important subjects for consideration, neither malpractice nor malpractice claims will be reduced significantly unless we improve the daily proficiency of otherwise competent but error-prone health care providers.

In this regard, Recommendation 9 is one of the most important. He recommends the immediate development of an insurer-sponsored risk management and loss prevention program. Currently, most risk management is simply claims management. Historically there has been little effort made at true loss prevention, i.e. identifying existing and potential sources for the occurrence of malpractice by physicians or by the personnel, medical or administrative procedures of hospitals. Only through active efforts at loss prevention will we be able to reduce the incidence of medical malpractice in this State.

The key to successful implementation of this program is to require insurers to invest resources in loss prevention. The Institute for the Study of Professional Risk strongly urges that this be legally mandated. Hospital personnel, and hospitals as entities, should also be required to undergo continuing medical and administrative education as a condition of their licensure. In addition, if health care providers are not legally required to be insured, the State should mandate that they have existing loss prevention programs as a condition of continued licensure.

Although malpractice resulting from the acts of truly incompetent physicians is certainly a smaller part of the problem, it may well be a larger part than is portrayed in the report. The Institute for the Study of Professional Risk strongly endorses Dr. Fleming's recommendation for a "major expansion" of the scope, authority and resources of the State's regulatory and disciplinary system. He is right when he recommends that this system no longer be focused on the "identification of the least competent provider". We must have a State disciplinary and regulatory system which requires the maintenance of high standards of medical competence and performance.

The concern of regulatory and disciplinary bodies that they may face lawsuits if they vigorously enforce disciplinary action against marginal providers can be easily resolved. The Institute for the Study of Professional Risk urges statutory immunity for disciplinary board members against suits by disciplined physicians or other health care providers. In formulating such protections and the procedures under which they would be applicable, ISPR urges the participation and assistance of the trial attorneys who would otherwise be involved in such litigation.

Dr. Fleming's suggestion for the establishment of "local, provider-sponsored quality assurance entities" could be meaningful under certain circumstances. Our medical schools can and should

be involved in the local and state medical disciplinary and regulatory process. The use of our medical schools in this way would be an effective method of moving away from the "least common denominator" disciplinary standard. It would help improve the quality of medical care and reduce the incidence of malpractice. A similar regulatory and disciplinary process should be instituted for hospital personnel and procedures.

Victim Compensation

The long-term recommendations regarding compensation of victims suggests creation of a liability fund and investigation of alternative dispute resolution mechanisms. The fund concept is not unique, but Dr. Fleming's suggestion that it be tailored to meet the needs of the "large award" and "long tail" cases is innovative and worthy of consideration. Several further measures which should accompany the creation of such a fund are:

a) Mandatory insurance to the base limit of the fund should be required of all health care providers;

b) The idea of financing the fund by a flat rate assessment against all physicians in the State increases the incentive for loss prevention activities. It would, however, be more equitable to require some private insurer participation in this fund. An alternative suggestion would be to require private insurer participation in the fund to the extent that private insurance rates were not reduced by its creation;

c) There should be some variance in the physician assessment based upon the 'claims-paid' experience of the individual physician or provider;

d) The liability fund should be placed in the same legal posture as a private excess insurer to encourage the underlying private insurer to fairly and accurately evaluate claims; and

e) Under no circumstances should the liability fund be administered or represented by the State Attorney General or other State office. It should function in the claims proceedings in the same role as a private excess insurer.

Dr. Fleming's recommendation for a thorough investigation of alternative dispute resolution mechanisms is a good one. However, any such mechanism must have the support of the users of the system. The existing State medical malpractice arbitration system has failed, not because of any constitutionality problems, but because the system was not perceived as being fair by injured patients or their attorneys.

As Dr. Fleming points out, there are many such alternative dispute resolution mechanisms, some of which are entirely consistent with the jury process. Efforts to develop a new mechanism must have the active participation of all parties, including victims' groups, physicians, consumer groups and the trial attorneys who will be advising future victims. It must be a system which is attractive to the patients and their prospective attorneys, as well as to health care providers. As its foundation, such a system must have a post-injury, voluntary election by both the injured party and the defendant.

SHORT-TERM RECOMMENDATIONS

The report demonstrates Dr. Fleming's experience both as a scholar and as a mediator. The short-term recommendations of the report are compromise suggestions designed primarily to entice the various interest groups to participate in the long-term solutions.

It is hard to justify some of these short-term proposals. For example, it is not clear why Dr. Fleming recommends certain "tort reforms" with just the general conclusion that "they might help". The report lacks any data supporting a relationship between the tort reforms which he suggests and, either the incidence of malpractice, or the level of malpractice insurance rates.

The fact that the remainder of his report is so well investigated and documented makes it questionable that there is any such relationship. Nevertheless, with exceptions, the short-term recommendations may well be a basis for a compromise.

The most notable exception is the recommendation for revision of the doctrine of joint and several liability. <u>If</u> mandatory insurance is required and <u>if</u> the excess liability fund is adopted, then the suggested revisions of the joint and several liability doctrine will be fair. In the meantime, as short-term recommendations, the revision of this doctrine will have an adverse impact on individual physicians to the unjust benefit of hospitals and their private malpractice insurers.

Notwithstanding these concerns, The Institute for the Study of Professional Risk joins with Dr. Fleming in the hope that these short-term "carrots and sticks" will provide an incentive for all

of the various interest groups to participate in meaningful discussion of long-term solutions to this situation.

Finally, Dr. Fleming's recommendation that a representative be designated to oversee implementation of his suggestions is important. The active involvement of such a person is required to bring about participation by all interested parties. Dr. Fleming's abilities in this regard are excellent and the Institute suggests that Governor Blanchard appoint Dr. Fleming to continue to serve in that capacity.